

Fall 1969

Jefferson Alumni Bulletin – Volume XIX, Number 1 Fall 1969

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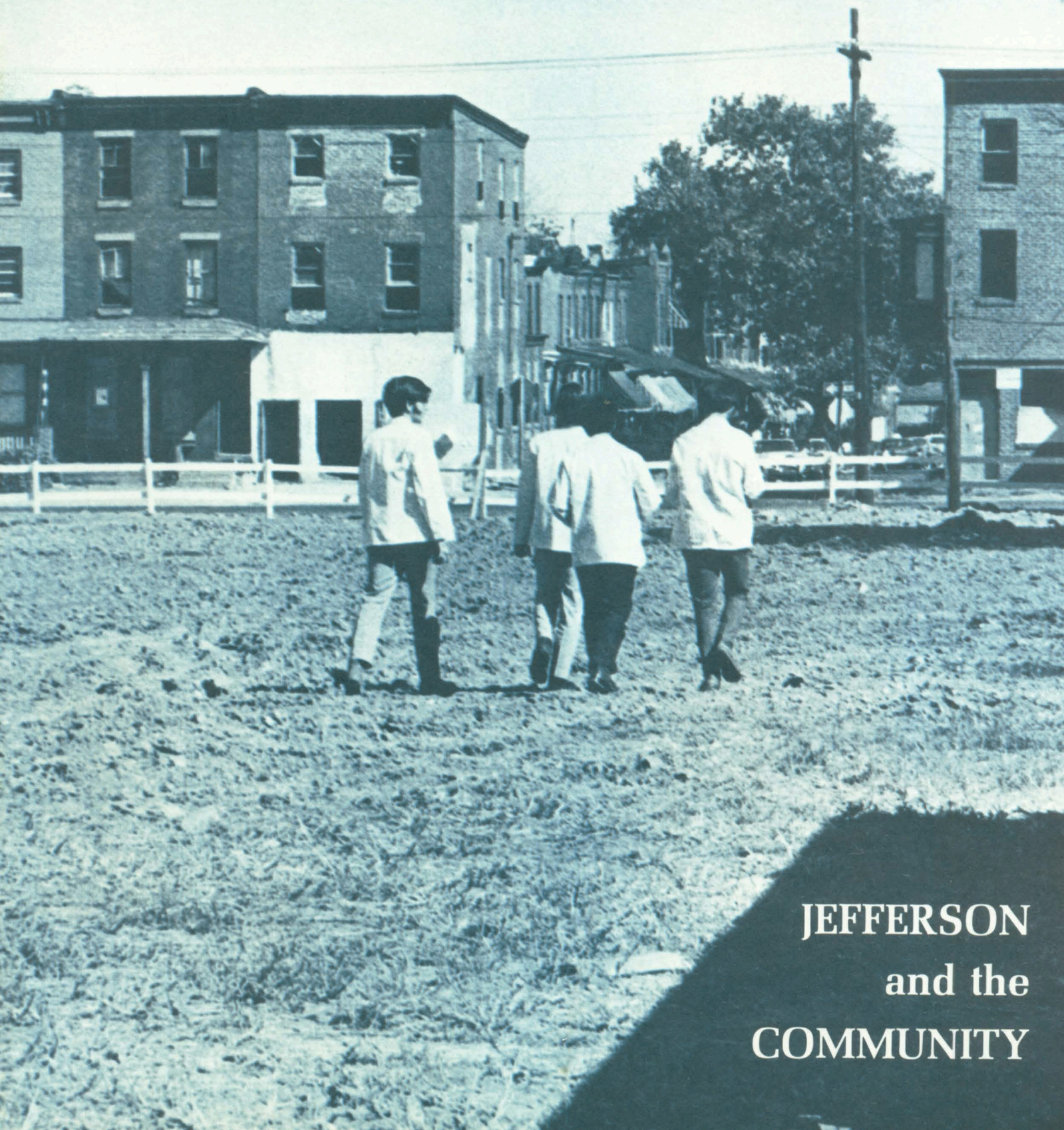
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Jefferson

MEDICAL COLLEGE

ALUMNI
BULLETIN


Fall 1969



JEFFERSON
and the
COMMUNITY

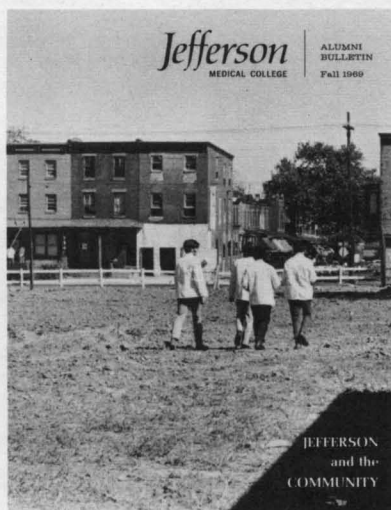
FFICE

The Academy of Music



On May 1, 1970 Jefferson alumni and their guests will climb these steps at the venerable Academy of Music in Philadelphia to hear the London Philharmonic play in honor of the Centennial Celebration of the Alumni Association. Following the concert (with Byron Janis as soloist) a champagne reception is planned at Jefferson Hall.

It will be a night to remember. It is a night to mark on your spring calendar now. Plan to join your classmates and colleagues in Philadelphia for the entire weekend for this tribute to your school and your Association.



IN THIS ISSUE

The fall ALUMNI BULLETIN features Jefferson's involvement with the community surrounding it. The realization that health problems must be treated in their social context has brought to the foreground new methods for distribution of health care. Some of these are explored here, as are some of the traditional methods. The occasions on which the community comes to Jefferson as well as Jefferson's reach out into the community are examined. Complementing the community health features is the "Profile" subject this time, Dr. Kalman Faber, Clinical Assistant Professor of Pediatrics. Dr. Faber is active in community health on an international scale.

The issue also contains another installment of the series on the physician in varied roles, this one by Dr. Norman Scott '46, Commander of the 249th General Hospital at Camp Drake, Japan. Prior to this Dr. Scott was Executive Officer and Chief of Professional Services, Letterman General Hospital, San Francisco.

On the cover: Some Jefferson students make house surveys in the Mantua community. Photography, cover and pages 2-37, by Sam Nocella.

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Jefferson in the Community: Children and Youth

by Edwin D. Harrington, M.D.

The Jefferson Children and Youth Program was made possible by what is popularly known as the "Medicare" law of 1965. Somewhat oversimplifying a very complex piece of legislation, it is still probably fair to say that there are four major components of the so called Medicare Act, only two of which were concerned with the aged. Another provision of the act underwrote the Medicaid programs throughout the country. The significant thing about both of these programs is that they simply provide mechanisms for buying whatever type of service is available in the area for huge numbers of people.

In contrast to these, the Children and Youth Programs, which were created under Title V of the legislation, are designed to serve small populations and to develop new and hopefully better methods of delivering care. The population served is restricted to a small geographic area so that the children served can be offered both comprehensive and continuing services. Medical services are defined very broadly to include pediatricians, nurses, social workers, psychiatrists, psychologists, nutritionists, dentists, physical therapists and occupational therapists. The legislation stipulated that these services be coordinated to provide the child and his family with a continuous care program. The area selected must be of demonstrable social and economic need; but once the area is selected, all children living in that area become eligible for preventive and diagnostic services. Children in poor families become eligible for all treatment and rehabilitation services.

the setting

There are fifty-eight Children and Youth programs in existence in the United States and its territories. In line with the attempt to design different methods of delivering health services, the Children and Youth programs present a great variety of different programs and approaches to care. Many of them are

Dr. Harrington is Program Director of the Children and Youth Program of the Department of Pediatrics at Jefferson. He holds faculty appointments in the departments of Pediatrics, Psychiatry and Preventive Medicine. He received his medical degree from the University of Pennsylvania, his undergraduate degree from Harvard and an M.P.H. degree from Yale.

similar to the Jefferson Children and Youth Program in that they are sponsored by a university medical school and serve a small circumscribed population adjacent to the medical center. The Jefferson Children and Youth Program serves the approximately thirty block area bounded by Broad Street on the West and Sixth Street on the East, by Spruce Street on the North and Christian Street on the South. All persons under nineteen years of age residing in this area are eligible for care in the Jefferson program.

A major problem facing medical schools in this area is the coordination of Children and Youth programs into an integrated system of care, avoiding duplication of services. The Chairmen of the Pediatrics Departments in the five medical schools sponsoring Children and Youth programs in Philadelphia recognized from the start that many services could not be efficiently supplied by one community program alone. Accordingly, they founded Compcare, Inc., to coordinate the programs and supply consultative services. One unique feature of the program is that a centralized computer will be shared by all of the medical schools involved and common methods of data collection and analysis will be used. Ultimately the Children and Youth programs may become part of a network of health services covering at least part of the metropolitan area. We are at the very beginning of this process of planning health services and coordinating activities of the various professionals and institutions involved. Within the individual programs, the need to develop collaboration between patients, professionals and institutions has become even more obvious. Our society demands that people taking care of us in health and sickness be both technically competent and humanely interested in helping us to cope with a variety of vicissitudes. In view of the technical and scientific advances made during this century, it is clearly beyond the capacity of an isolated individual to render comprehensive care in the physical, social and emotional areas on a continuing basis.

One development in the search for new methods of delivering health care is the interest in a multidisciplinary type of "primary" group as distinguished from the traditional medical group practice. Essentially, this notion accepts the fact of specialization and recognizes that the primary physician cannot fulfill all of the responsibilities involved in providing primary health services. There is progressively more



experimentation with teams of pediatricians, nurses, social workers, psychiatrists and others serving as the primary caretaking group for the children in the family. These small primary groups are frequently related to a larger group practice or an institution geared to the typical group practice. The Jefferson Children and Youth Program represents one of a very large variety of attempts to set up a primary group of caretakers (a pediatrician, a nurse, a social worker and a child psychiatrist) working in relationship to the Jefferson complex so that this primary group is itself supported by a complete battery of subspecialists.

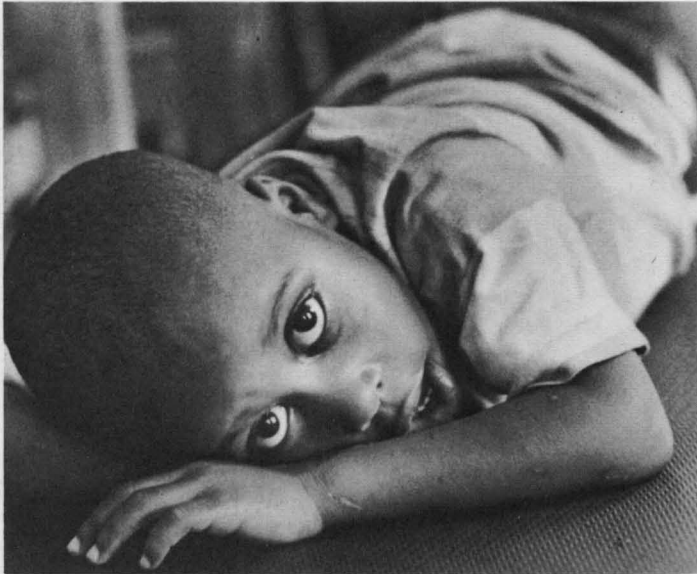
The twin demands that the physician have a rational basis for his therapeutic attempts based on available scientific technology and that he relate this to a continuing program of care to help an individual reach his capacity, have created a responsibility which many people believe can be met only through a collaborative effort. This set of demands has altered greatly the nature of the physician's involvement with his patients. The physician has frequently seen the patient as demanding (as, in fact, he is). But even a casual look at contemporary literature on the subject indicates that the patient perceives the physician as withdrawing from the support functions which the patient feels are important into areas of specialization in which he seems to deliver technical excellence in an impersonal way. (Again probably quite correctly, the patient perceives the physician as withdrawing from an emotionally impossible task.) The purpose of experimentation with collaborative efforts is to develop new ways of meeting this dual responsibility so that the task is both accomplishable and emotionally possible for both the professional and the patient. Essentially, the Jefferson Children and Youth Program is one of a large variety of experimental medical care programs wrestling with this nuclear problem.

Jefferson specifics

Planning for the Jefferson Children and Youth Program began in 1965 but increased in tempo after the grant was funded in September of 1966. Although some clinical activities were started in the Curtis

Clinic, the program opened its own facility at 1332 Fitzwater Street in January of 1968. We were fortunate in obtaining what had been the center city offices and clinics of the Eagleville Sanatorium. It is symbolic of the changes in medicine that a facility which had been a voluntary agency for the treatment of a contagious disease has been converted into a neighborhood clinic run by a university but supported by federal funds and geared at long-term health supervision rather than at any specific disease category. Although there are always some disadvantages to taking over a previously used building, the Eagleville offices lent themselves to modification. We now have a three story building with appropriate clinical examining rooms and space for conferences with families and community groups. In addition, the building contains a waiting room, a playroom for children, a pharmacy, a demonstration clinic, facilities for testing hearing and vision, as well as offices for nurses, social workers, psychiatrists, psychologists and homemakers. All physicians are full-time members of the Jefferson faculty, most of whom have offices at the medical center and simply use working space in the neighborhood center.

Our activities have expanded steadily since the building was opened. We now have five teams each made up of a three-fifths time pediatrician, a social worker and a nurse. A consultant child psychiatrist and a nutritionist are present at all team meetings, and a full range of technical subspecialists are available through the Pediatrics Department. We are now caring for approximately one thousand families with a little over three thousand children registered in the program. Data on the exact population of our census tracts is old and unreliable, but the best estimate places about 4,500 children in our target population. This means we have registered approximately three-fourths of the children in the area. In the last year, there were ten thousand visits to the clinic. Some six hundred of our children were seen in the Jefferson Emergency Service and three hundred children were referred to specialty clinics. There were 676 visits to the Dental Clinic. Approximately sixty-five children were hospitalized at Jefferson on either a medical or a surgical service.



In addition to the Project Director, there are five staff pediatricians and a Pediatric Fellow in the program. All the staff pediatricians are Board certified. A Fellow must be Board eligible. All participate in the revised residency program in pediatrics at Jefferson.

One of the most exciting things about the program has been the opportunity to wrestle with the problems of on-going medical care in an academic setting. Our pediatricians have had no prior experience as "team leaders." This has been a sometimes painful, but always exciting, process in which we learn to work together. Trying to follow families on a regular basis is a difficult and often frustrating business. We find that medical students tend to assume that isolated facts presented by a highly specialized faculty can readily be synthesized and managed in an integrated fashion by practicing physicians. In reality, synthesis itself is a sophisticated technique which certainly cannot be taken for granted. Several students have commented that watching our doctors struggle with the problems involved in delivering care has been a revelation to them. This not because they were under the impression that we had the answers, but because they had begun to have some feeling for the complexity of the problem. This is the kind of empirical

tone which we have tried to cultivate in the program. We have offered a seminar Pediatrics 505, An Introduction to Comprehensive Clinical Pediatrics, in which we try to demonstrate and discuss what we are doing. We also offer a clinical clerkship in which a student works with us for three months. In a sense, we are attempting to revive the old preceptorial methods of teaching, but in an environment which recognizes the complexity of delivering care and does not pretend to have ready answers. The essence of the physician's job would seem to be not so much the accumulation of information, as the selection of appropriate information and skill in applying it in the interests of the patient and in support of his colleagues engaged in the same process.

The Children and Youth nursing staff consists of a Chief Nurse and five staff nurses, as well as two nurse's aids and a Children's Activity Specialist who supervises the play area. There are also two Public Health nurses who work exclusively in our "territory." All of our nurses have at least a Bachelor's Degree and all of them have had extensive in-service training in interviewing and health supervision. They are able to perform many functions not traditionally done by nurses. In the fall of 1969, members of the pediatric nursing staff from the Jefferson Hospital started rotating through the Children and Youth Program for one month at a time, to further integrate our nursing program with that of the mother institution. Although our pediatricians take care of their own patients, both in the community and in the hospital wards and nurseries, the nurses also follow the families. This is so that the kind of therapeutic milieu which we are trying to create in the community is carried into the hospital and hospital clinics.

The Social Service Department consists of the Chief Social Worker, five team social workers, two community-based social workers, and one Community Organizer. All of our social workers have Master's degrees. They are supervised in their casework by the Chief Social Worker and in their group work by Dr. Helen Phillips. In addition to the regular social work staff, we have two students receiving field training on a three days a week basis. One of these students is a candidate for a Master's degree; the

other, a candidate for a Doctor's degree.

The program also has four homemakers who assist the families and a task force of two people who follow up on broken appointments. There is an active Neighborhood Advisory Council. The program and the local community publish a Newsletter, "The 1332 News."

One psychiatrist and one psychologist are with the program on a full-time basis. Another psychiatrist works with us on a half-time basis and is responsible for developing and supervising our in-service training program. Another part-time Ph.D. in Psychology works with one of the teams and supervises the full-time psychologist. The demand for direct psychiatric services far exceeds our ability to supply it, although we do considerable short-term therapy. We also work with both the Jefferson Community Mental Health Center and the Pennsylvania Hospital Community Mental Health Center.

The program uses the children's dental facilities at the Sausser Dental Clinic. We also offer nutrition services and limited obstetrical services, as well as having a part-time consultant in internal medicine available to us.

the "typical" patient

Perhaps it would be helpful to sketch out what happens to a "typical" patient as he goes through evaluation in our program. The child is usually brought to the clinic for the first time by his mother because of some acute event or minor sickness. On this episodic and unscheduled visit, he is seen by a pediatrician who cares for the immediate concern. Either before or after being seen by the doctor, depending on the urgency of the case, the mother is given a Registration Interview by a non-professional working under the supervision of our Social Work Department. Where the doctor's interview is focused on the immediate concern of the mother, the purpose of the Registration Interview is to find out how she happened to bring the child to us and what she is looking for in a broader sense. We can learn the composition of the whole family and get some idea of what the mother's priorities are as we move in to help the



1332 Fitzwater Street, program headquarters.

children. Since the interviewer does not have a professional background, the interview is not biased in the direction of the physician's traditional interests. The mother's perception of her children's needs determines the next step in the evaluation process. Usually arrangements for a further meeting are made before the mother leaves the clinic. Of course, the mother's option not to return at all is always left open. A study of one team showed that twenty percent of the team's patients receive episodic care and nothing else. This means essentially that these families come in to see us when something goes wrong but do not come back for a more thorough evaluation.

Let us assume that at the episodic visit the mother says she would like a careful history and physical examination of one of her children. She is then scheduled to return with the child for this care, which leaves the physician and the mother satisfied that the child does not have any serious biological disorder. But this does not usually give the physician and nurse enough understanding of the mother's view of things to set up a long-term program. Essentially, this is the kind of work-up that is considered good basic care evaluation. It allows the professional to reassure the mother about specific concerns and to give her directions about specific illnesses. Analysis of one team showed that fifty-seven percent of its patients reach this level of good biological care but go no further. Our experience has been that this does not enable the family to plan continuing and comprehensive programs for their children.

In planning any long-term program or any rehabilitation program, it is essential that the program be developed by the family on a complete understanding of the total situation. The mother in this situation would be offered an opportunity to return without the child for a Continuing Care Interview. This interview reviews the mother's expectations, but also goes over events in the child's life, including biological contingencies, how the child adapted to them and how the family helped him to cope with them. The interviewer then reviews the mother's background to get a picture of how she copes with events and to learn her child rearing patterns. In medical care circles, there has been little theoretical disagreement that this

kind of information is valuable; but in the individual practitioner's situation and the traditional group practice situation, there has not been time to develop this kind of relationship. In order to meet this need, the Jefferson Children and Youth Program has not only developed a generic interviewing instrument (the Continuing Care Interview) but also has trained each member of the team in its use. This means that for any given child, either the pediatrician, the nurse, the social worker, the nutritionist or the child psychiatrist can carry out this time-consuming and emotionally involved part of the initial assessment.

On completion of this interview, no attempt is made to counsel the mother. We feel it is important that she and the interviewer consider any given problem in the light of their study of the total review of the past. We also tell the mother that the other members of the interviewer's team would like to review the information. The information collected is studied by a panel of experts, in a sense. In short, before a child is considered under health supervision in our program and before a comprehensive care plan is devised for him, one of the team members interviews the child's mother. The team member prepares a summary of



Dr. Edwin D. Harrington, Director.

the apparent assets and liabilities of the child and his family. He outlines a tentative long-term care plan for the child's preventive health care, which he presents, along with the results of the child's physical examination, to a conference of the entire team. The team then develops a revised plan. This plan is submitted to the child's family in a conference attended by the original interviewer, usually the pediatrician, and the specialist who will be primarily involved in carrying out the plan. At this point, the primary caretakers have an opportunity to learn what the family feels after reviewing their situation. Together they further revise the plan according to the family's interest. The staff members who attend this Family Conference become the family's primary care group and are responsible for maintaining continuity of care.

There are three basic ideas behind this process. First, the family has a minimum number of professional contacts. It would be possible to have this process carried through entirely by the pediatrician. It is fairly common to have it carried through by the pediatrician and the nurse. Second, since the

material is reviewed by a panel, the family has the benefit of the highest possible level of expertise in making judgments. Third, the family is helped to approach individual problems in the light of its overall priorities. Again, in the case of the one team studied, twenty-three percent of the patients had reached the level of care in which the family and the professionals operate as peers within a care plan that is basically developed by and thoroughly understood by the family. We always have known that a plan of this type was necessary when the child had a chronic illness such as poliomyelitis. The belief that the Jefferson Children and Youth Program pursues is that children without specific handicaps can benefit from the same kind of planning, if this is what their families wish.

the indicators

One of the most exciting things about Children and Youth programs, from a professional point of view, is that for the first time a physician at a medical center has been assigned a definite population for which he and his team are responsible. For the first



School bell rang five minutes ago.



Lunch time means play time.

time, comprehensive follow-up is theoretically possible. A true preventive clinical medicine should be possible if we can develop the necessary skills.

One indication that we are to some extent succeeding in following the children of the community is that the age distribution of children in our practice differs markedly from that of a typical pediatric practice. In the classical pediatric practice, the vast majority of children are under two years of age. In the Children and Youth Program the age distribution of the patients tends to be a fairly straight line, not heavily weighted in the direction of infants. This is a very difficult situation to interpret. It is possible, at least, that we are serving the community on the basis of its need, rather than according to the doctor's selection of patients with whom he is most comfortable or feels the greatest expertise.

Perhaps the most important asset of community-directed programs is the enthusiasm among the people the project serves. This is shown by the activities of parents of the children. Many participate in clinic-sponsored parents councils to mobilize neighborhood efforts towards community improvement. Others babysit for mothers who are taking their children to the clinic. Some give their time in the clinic or the community as volunteer aides, supervising the play area in the clinic waiting room, assisting in mass screening programs. The teenage girls are participating in a "Mini-mom" program which helps the



Inside the Hawthorne Community Center each gang has a wall to decorate.

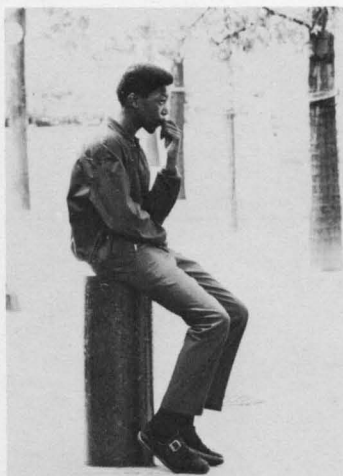
younger children and also trains the adolescents. It is really rewarding to see the apathetic "clinic patient" begin to develop his own health plans and take responsibilities in a way that had not seemed possible.

Admittedly, the Jefferson Children and Youth Program uses the parents' immediate preoccupation with what is frequently a minor episodic event to help them through a process which hopefully will lead to better family organization and ultimately to stronger ego organization for the children involved. We hope to help a family deal with a biological contingency in a child in such a way that it is richer for the experience and better able to help the child grow up to become an autonomous and a caring human being. We do not see this as a massive effort in insight therapy, but rather as an essential part of the routine work of all professionals who try to help in this small community which we serve.

In the last analysis, the development of a more human and supportive technology depends on the humanization and sensitization of all of our institutions. We may have reached the point where previous advances in technology make it possible to take this next step forward. We do not know in detail how this is to be accomplished, but one thing seems clear. We must apply the same general principles of careful trial and error, formulation of hypotheses about delivery of care and testing of those hypotheses that have been successful in all other activities.



Jefferson's Children and Youth Program, serving a geographically restricted area, now gives medical care to young residents such as these. The program, offering both comprehensive and continuing service, features a team approach to health care. The team includes pediatricians, nurses, social workers, psychiatrists, psychologists, nutritionists, and physical and occupational therapists. If appearance is a factor in its evaluation, the Children and Youth Program beams success.



Jefferson in the Community: Mental Health

by Elaine Smith

Mrs. Smith is Mental Health Education Specialist with the Community Mental Health Center. She is a University of Pennsylvania graduate and is pursuing a Master's degree at Bryn Mawr. Mrs. Smith is married to Dr. Robert Smith, class of 1957.

A teaching hospital located near a deprived economic and diverse racial community assumes a social responsibility to the world beyond its walls. In the spirit of reaching out to this community, Jefferson's Community Mental Health Center was opened in July 1968. The Center is sponsored by the Department of Psychiatry and funded by federal, state and local government resources. Under the Commonwealth of Pennsylvania Comprehensive Mental Health Plan, Jefferson was given responsibility for serving that area of Philadelphia west of Broad Street to the Schuylkill River and south of Chestnut Street to the Navy Yard, plus a small downtown section east of Broad Street surrounding the Hospital.

The goal of a mental health center is to make services available and accessible, to insure that the range of services is comprehensive, to promote continuity of service and to prevent hospitalization. In short, the task at hand includes not only treatment, but also prevention and early detection of mental disorders in a geographically determined community. In order to achieve these objectives, the Center provides inpatient, outpatient and emergency care, partial hospitalization, half-way house facilities, rehabilitation programs, and a wide range of community consultation and education services on a continuing and coordinated basis. Since the start of the Jefferson program the Center has treated more than a thousand patients from the service area, and offered a number of innovative programs to community agencies and groups. The Chairman of the Department of Psychiatry, Dr. Floyd Cornelison, and the Director of the Community Mental Health Center, Dr. Daniel Lieberman, have tried to relate the growth of new services to the needs of the University as well as to the needs of the community. The following will describe some of the services currently being offered by the Mental Health Center.

inpatient services

Inpatient services for catchment area residents include primary short term adult services at a special unit at Philadelphia General Hospital. The Director of the PGH Inpatient Unit is Dr. John Mock who works with a staff of mental health personnel in an interdisciplinary approach to short term treatment. Treatment in the Jefferson Unit at PGH is coordinated with the Day Treatment Program offered at the Center's

main facility, the John E. Davis Center at 1127 Walnut Street, as well as with rehabilitation, outpatient or other needed services. The other major inpatient facility is at Philadelphia State Hospital where Jefferson is responsible for the care of more than six hundred patients. Under the terms of this contract, Jefferson provides staff to work along with the staff of Philadelphia State Hospital. The program there focuses on the resocialization and rehabilitation aspects of treatment so that patients can be returned to community life more rapidly and in greater number. Various innovative approaches to treatment have been instituted in this program under the direction of Dr. Maurice Linden. This includes intensive group therapy, additional occupational training and expanded recreation services. At the end of the first year of operation in September, more than one hundred patients had been discharged from the Jefferson Unit. The Center also has relationships with inpatient services at Jefferson Hospital, with the inpatient service at Spruce House and with the Eastern State School for Children.

outpatient facilities

The goal of a mental health center, of course, is to prevent hospitalization and rehospitalization through alternative treatment methods and through continuity of care. Recognizing this, a Day Treatment Program was made a first priority of the Mental Health Center. In this situation patients who formerly would have been hospitalized are now placed in a program which meets daily from 9:00 a.m. to 4:00 p.m., Monday through Friday. Patients return to their homes evenings and weekends. Through utilization of group therapy techniques, continuous counseling, various recreation activities, plus art, music and dancing therapy, patients who are seen in this kind of outpatient setting maintain their ties with family and community life. The staff also meets with families in the evenings at various social events which are planned by the patient group. Vocational counseling, preparation for job hunting, good grooming classes and other rehabilitation services are part of the program.

Other outpatient facilities for adults are under the direction of Dr. Merlyn Demmy '56, at the Davis Center, and Dr. Robert Brotman '57, at the Satellite Clinic, Broad and Morris Streets. The greater volume

of patients is seen in the Satellite Clinic. This facility is staffed by a broad range of mental health personnel capable of rendering service to all types of patients regardless of their age, socio-economic status or psychiatric disorder. The staff provides a number of consultative services to agencies in the area, to the public health nurses, and to St. Agnes Hospital. A unique aspect of the Satellite Clinic is the home visitation program for patients who are unable to take advantage of mental health services in a clinic setting. Both adult patient clinics have practically eliminated waiting lists for patients. In most instances, walk-ins are seen immediately.

Psychiatric services to children also have expanded through the Community Mental Health Center's Children's Service Unit. Under the direction of Dr. Ora Smith, a fluid referral system has been worked out with elementary and junior high schools in the catchment area for treatment of children with mental health problems and consultation to counselors, teachers, and parent groups. The Children's Service Unit has worked closely with the Center's School Consultation Service over the past year and they will be even more closely related in the future. Aside from seeing individual children and families, the staff of the Children's Service has consultative relationships with the Hospital's Nursing and Pediatrics services and with a child day care center in South Philadelphia.

The Center provides other indirect services to the community, such as training community workers on the staff of the Philadelphia Anti-Poverty Action Committee, which covers the Jefferson catchment area. Another program set up weekly meetings of single parents in one of the area elementary schools. The focus here was on problems of child rearing in a one parent family as well as other mutual problems. So enthusiastic was the response to this program that the service has been extended in the coming year.

There are hazards and rewards of increased community involvement, and one of the treatment programs conducted by Children's Service illustrates some of these. A series of meetings with groups of adolescent boys and girls was held in one of the junior high schools which serves a low income neighborhood. The groups were set up at the request of the school because some students were presenting behavior problems in the classroom. What the staff

found when they met with the students was far more complicated than the usual problems of "the generation gap" or the underachieving student. The most pressing problem that these students saw was day to day survival. One of their friends had been killed recently in a gang fight. Fighting, in fact, was often a necessary and accepted fact of life in the community. Drug addiction, prostitution and gambling were equally familiar occurrences. Thus, the school was imposing on students, not only an irrelevant education program, but also a value structure which conflicted with parental and community expectations in significant ways. How does a center relate to the issues with which these adolescents must deal? What role does the Center play in bringing the schools and families closer to an understanding of each other and the children? These are the day to day questions with which some of the clinical staff deal.

emergency services

Emergency Services too, are available on a continuing and coordinated basis. Twenty-four hour psychiatric emergency service has been established within the Jefferson Hospital Emergency Room. In addition, a Crisis Intervention Unit has been installed within the Jefferson Service at Philadelphia General Hospital. This service works closely with all operations of the Mental Health Center and with other community agencies to provide intensive short term treatment for various kinds of psychiatric emergencies and to explore alternatives to hospitalization. Walk-in emergencies are, of course, seen in both the Davis and Satellite Clinics. The Center has worked closely with the Police Department and with such agencies as the Suicide Prevention Center to make these services relevant to their needs as well as to the needs of residents of the catchment area.

aftercare and rehabilitation

Central to any concept of continuing care and effective return to community life is the need for after-care and rehabilitation. The Community Mental Health Center provides this primarily through a contract with the Horizon House, a long established agency in the aftercare and rehabilitation field. Very often, patients who have experienced long term hospitalization are in need of a variety of resocialization experiences as

well as vocational training, rehabilitation and placement. Horizon House staff members are placed within the various service units to provide this kind of continuous treatment. In addition, a sheltered workshop is available for use by patients in the Mental Health Center program. Individual and group personal and vocational counseling, half-way house arrangements, help in locating boarding homes and resocialization classes in such things as good grooming, cooking, and finding employment are offered through this program.

Aftercare and rehabilitation services for the community have expanded in scope as well as size. Three resocialization centers have been set up in South Philadelphia, two in churches and one in a public housing project. Health workers from the area work not only with former patients, but also with community residents around various problems of living. In one of the Centers, for example, a high school equivalency program has been established for the area residents. In another, a summer program for mentally retarded children was set up. The third has developed an extensive job training and placement service for area residents as well as ex-patients.

Another innovative service of the Aftercare and Rehabilitation Unit involves weekly meetings with boarding home owners. The areas of concern at these meetings are patient adjustment and environmental factors relating to it. In this way greater insight is given to the people who must relate to former patients on a day to day basis. So far, this kind of consultative relationship has proven to be of significant value to both patients and boarding home owners.

indirect services

Indirect or preventive services are an important focus of the Community Mental Health Center Program. Since the goal of a center involves not only the treatment of mental disorders, but also their early detection and prevention, consultative and educational services have been set up to work with primary "care-takers," such as clergy, agencies, schools, health professionals, and with neighborhood level groups and civic organizations. Consultation and Education Service activities, thus, have focused on assisting persons in the helping professions to better cope with mental health problems as well as to provide a treatment resource for specific cases. The Center's School Consul-

Courtesy of the Philadelphia Inquirer



In some cases, a special approach is called for. In Philadelphia's Rittenhouse Square Carol Rudman, a young worker, suggests to an addict treatment at the Community Mental Health Center.

tation Unit, for example, has worked closely with the Children's Service in the past year, although its primary focus has been toward modifying the learning environment for children to reduce the prevalence of mental disorders. Workshops and conferences have been held with teachers and counselors in the catchment area schools for this purpose. In these programs it is crucial to involve parents. A program of this kind was pursued at the Arthur School through its Follow-Through program. This was intended to reinforce the gains made by children in Project Headstart, the federally funded pre-school program for children from economically disadvantaged areas. The approach used at the Arthur School stressed parental involvement in a behavior modification method which was used to reinforce positive learning experiences among the students. A unique aspect of the project was the provision of scholarships for parents who participated in extensive training at the school followed by intensive work with the students in class and at home. The School Consultant from the Jefferson program met with teachers and parents to teach them methods of operating and to discuss learning experiences of both parents and their children. The fact that the school is asking for an expansion of the program in the coming year indicates that positive gains are being made.

working with clergy

Consultation services to clergy have resulted in a number of collaborative relationships. A conference of South Philadelphia Clergy, representing all faiths and walks of life, has convened on numerous occasions to discuss areas of community concern such as housing, drug addiction and education. The Jefferson consultant to the clergy, in fact, received an award from the Community Relations Commission for his work in organizing this group.

Consultative relationships also have been established with a number of social agencies such as the Department of Public Assistance and the Youth Conservation Service. Case and program consultation has been an on-going arrangement with these and other groups for the past year. In the coming year more consultative arrangements are planned with police and law enforcement agencies and other health and voluntary agencies. By adding a mental health com-

ponent to the agencies such as these, which are already operating in the service area, the Center is attempting to help the community solve its own mental health problems.

Other indirect specialized services are provided to neighborhood groups and individuals. The Community Organization Unit, for example, works more intensively in the central part of the catchment area. Here assistance is given to neighborhoods to develop the motivation for making significant changes in the community. In one neighborhood a five year economic redevelopment project has been planned by residents of an area which was formerly slated for demolition by the City. Numerous self-help groups have sprung up from this effort.

In the area of public information, the Center has established relationships with all of the media as well as communications with various neighborhood groups in the area. When called for, a specialized approach has been utilized. One case of this is in the Rittenhouse Square area. Here it was found that some of the alienated youth could only be reached through the employment of someone with a strong identification in the neighborhood. The young art student who was hired makes contacts both in person in the "Square," and through the use of the underground press, rock and roll stations and stores in the neighborhood. Appropriate cases are referred to one of the Mental Health Center services; others are "counseled" on the spot.

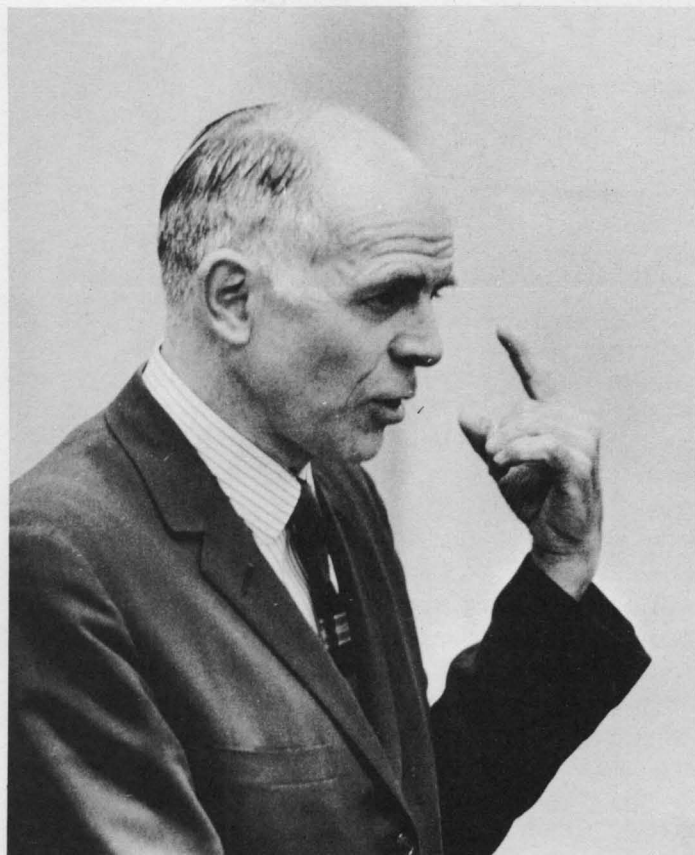
Other Center services include research and evaluation and in-service training. The Research and Evaluation Unit provides on-going evaluation of all programs and the In-Service Training Program provides for staff development and professional training of medical students, interns, residents, and other health professionals within the University.

In the coming year, the Mental Health Center will be adding a Mental Retardation Unit and a Family Therapy Unit. The Center is attempting also to bring additional services for drug addicts into the community.

The community Mental Health Center in these ways has tried to put Jefferson's resources to work for the benefit of the community. In doing so the rewards have proven to be mutual, as has the importance of the goal, that of improving the quality of life in the community.

Kick the Smoking Habit?

THERE IS A WAY!



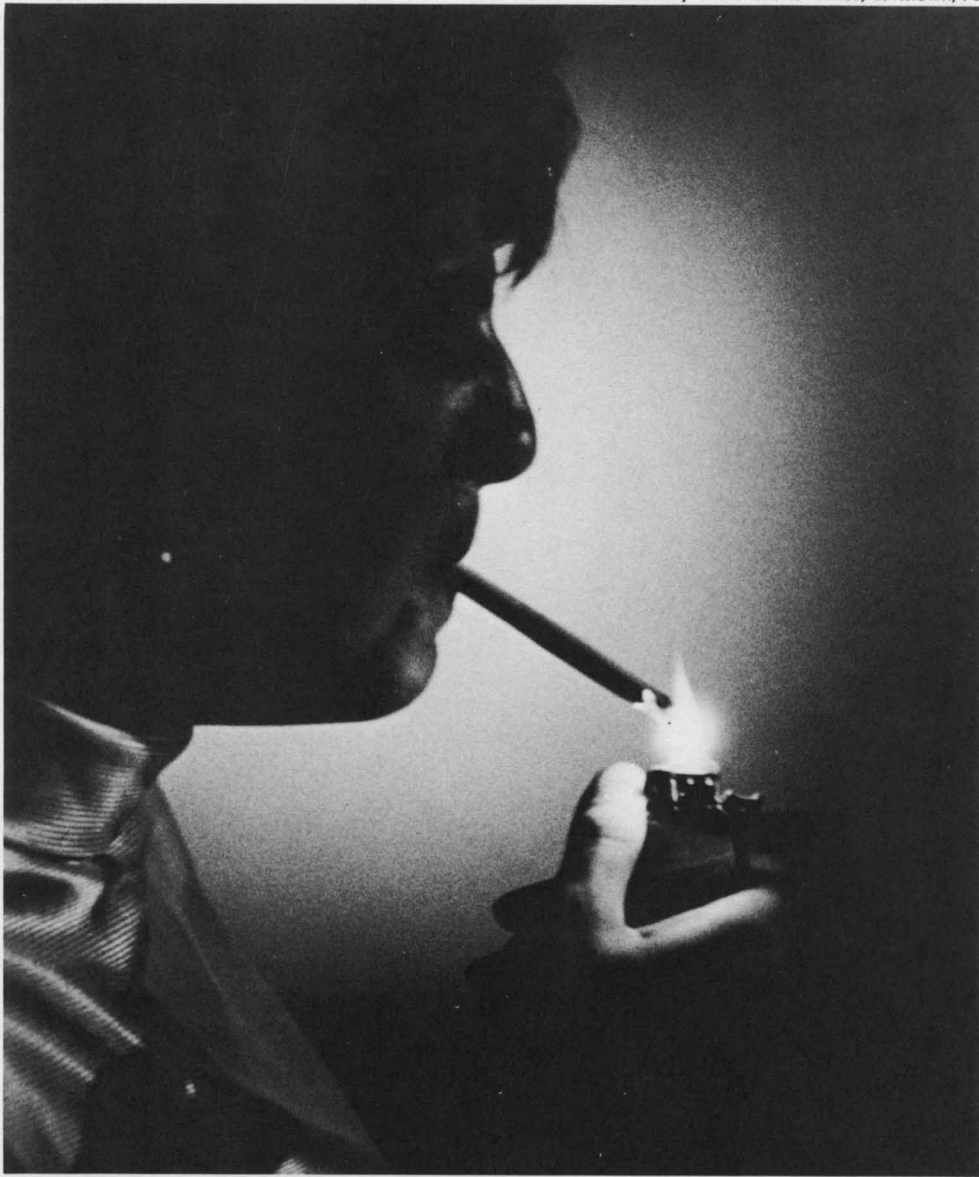
Dr. J. Wayne McFarland, Director of Five Day Smoking Plan.

Yes, there is a way out for the tobacco addict. There's even hope for the hard core of smokers who would like to quit, but . . . well, after you've smoked for thirty years, you know how it is. One man who does know how it is and decided to do something about it is Dr. J. Wayne McFarland, Assistant Professor of Medicine. Easy mannered and soft spoken, he never has smoked. But his "Five Day Plan to Stop Smoking" may be the biggest boon yet to people who do.

Dr. McFarland got interested in the smoking problem early in his career, when he began his practice at a peripheral vascular clinic in California in 1939. The patients there suffered arterial disease and in some cases, he says, "it was give up cigarettes or lose a leg or a foot." Still some patients smoked. Dr. McFarland began to think about it. Is it fair to ask a man to quit and not help him? He decided it wasn't and immediately set to work devising a ten day program to assist victims of the habit. A graduate of Loma Linda School of Medicine, Loma Linda, California, he took his plan to Pastor Elmer J. Folkenberg, a clergyman at the Seventh Day Adventist owned and operated university. Pastor Folkenberg advised reducing the time to five days—to keep pace with a fast moving world. From their combined efforts emerged the Five Day Plan. They first trained physician-clergyman teams, who experimented with the plan in small villages. Today, eight years later, the Five Day Plan is in use all over the world and in every state of the U. S. In Philadelphia the Five Day Plan has received Jefferson's full support. Most important, it has the confidence of those who have tried it and come out quitters.

Hard core smokers who have made the break consider it a near miracle. "I just couldn't stop smoking," one Philadelphia woman wrote Dr. McFarland. "I had tried before and after attending your classes at Chestnut Hill Hospital, I stopped for six months." But with one cigarette, she broke the record and couldn't get a day in afterward without smoking. "So I came to your classes again." Convinced she was permanently addicted, she was assured by Dr. McFarland that if she didn't give up, he wouldn't either. She didn't and she no longer smokes.

In the three years that Dr. McFarland has been conducting the program at Jefferson, 2,500 individuals have attended the courses. The classes are sometimes held at the Medical Center, but often Dr. McFarland takes the program to outlying points in the community. Attendance averages between one hundred and two hundred persons each night. "Our larger groups of two hundred or more have the same rate of success as groups of twenty-five to fifty that we've conducted," says Dr. McFarland. The basic format for



The last drag.

the program is a series of five lectures given by a physician. Films on the risks of the smoking habit supplement these. "Knowledge isn't enough though," is Dr. McFarland's approach. The Plan attempts to give the participant enough incentive to make it through the first five to seven days of not smoking. One source of this incentive is Dr. McFarland himself, who has what his smoking patients call "charisma." Of course, the participants are also given specific advice, including a detailed outline of what to do on a twenty-four hour basis. The participant's physical, mental, social and spiritual conduct during this period are given careful attention. He smokes his last cigarette before entering his first session of the Five Day Plan. "Tapering off is often tiresome, painful and uncertain. We suggest that the individual put up with three to five days of discomfort and be done with it, rather than torturing himself for three to five months," Dr. McFarland says.

At his first class the participant is taught how to meet the peak craving. One method is the buddy system (each person is assigned a partner in the group on whom he can call for support). But the key to the success of the program, many of its graduates feel, is the phrase, "I choose not to smoke." "It's hardest the first three days," says the Doctor, "but no deaths have been reported as a result." Breathing exercises are very helpful too, the graduates report. The Five Day Plan also calls for avoidance of all sedatives and stimulants—including alcohol, coffee and tea. "The caffeine stimulates the identical nerves that we want to keep calm," he explains. And what goes with a martini or a cup of coffee? A cigarette, of course. This habit pattern must be broken. And what if that feeling of "I can't stand it any longer" sets in? Well, you can hop into a nice warm shower. "It's pretty hard to smoke in the shower," the Doctor observes.



Kicked the habit.

Dr. McFarland has given a considerable amount of study to the tobacco habit. "The problem is one of both physiological and psychological addiction, as well as a deeply ingrained habit. One only has to see some of the withdrawal symptoms and the severe craving which many of these patients have to be convinced that the problem is a very deep seated one." Dr. McFarland feels that the group dynamics of the Five Day Plan sessions play a big role in assisting the tobacco addict to stop. The same can be said of the fact that the Plan addresses itself to the problem from every facet of living. The plan is accessible to all, as the charge is a nominal five dollars. The regimen of the program borrows from Alcoholics Anonymous, and Dr. McFarland makes no apology for this. The formula is working for many addicted smokers who never have seen their way out before. "Seventy to eighty percent of the patients can stop smoking in five days.

By this time the withdrawal symptoms of nervousness and headache are controllable or have disappeared. If you include patients who have cut down to one half or more of their previous smoking, the success rate is between eighty and eighty-five percent."

But how does the Five Day Plan withstand the acid test? How long does the "quitter" stay off his cigarettes? Follow up work on the program shows that thirty percent are still non-smokers at the end of a year. This compares favorably with the results of all clinics conducted in the United States, which indicate that ten to fifteen percent are still not smoking at the end of a year. With a closer follow up and more frequent meetings with graduates of the course (they now meet monthly), Dr. McFarland is hoping to bring the figure up to forty percent. Judging by his past success in helping people to live without smoking, the goal is as good as won.

Everyone in medicine is aware of the changing appearance and structure of the outpatient clinic. Social pressures in America have caught up with this aspect of medicine, and the clamor for change seems to stem from the consumers of the medical service, the patients, as well as the suppliers, the physicians, and those who pay for the service.

An obstetrics clinic, in spite of traditional unpopularity with physicians, is a nearly ideal place to examine the impact of these changes, for nowhere else in the outpatient department are there so many patients with the same diagnosis. While it is easy to

contrast, there has been a slight reduction in private deliveries that is much less than the general decline in private births experienced elsewhere in the city. Perinatal mortality rates on the two services have consistently shown the percentage of deaths among infants of service babies to be almost twice that of private babies.

some unsettled questions

The bad outcome of pregnancies among our service patients has raised questions about the structure and purpose of prenatal care. The questions have been

Community Service Through the Clinic

by John B. Franklin, M.D.

generalize about pregnant women, there is increasing evidence that the forces compelling social change have had adverse effects on the outcomes of the pregnancies. As a result, prenatal care has emerged as one of the areas where major changes in the goals and structure of the service must be considered to meet the contemporary social situation.

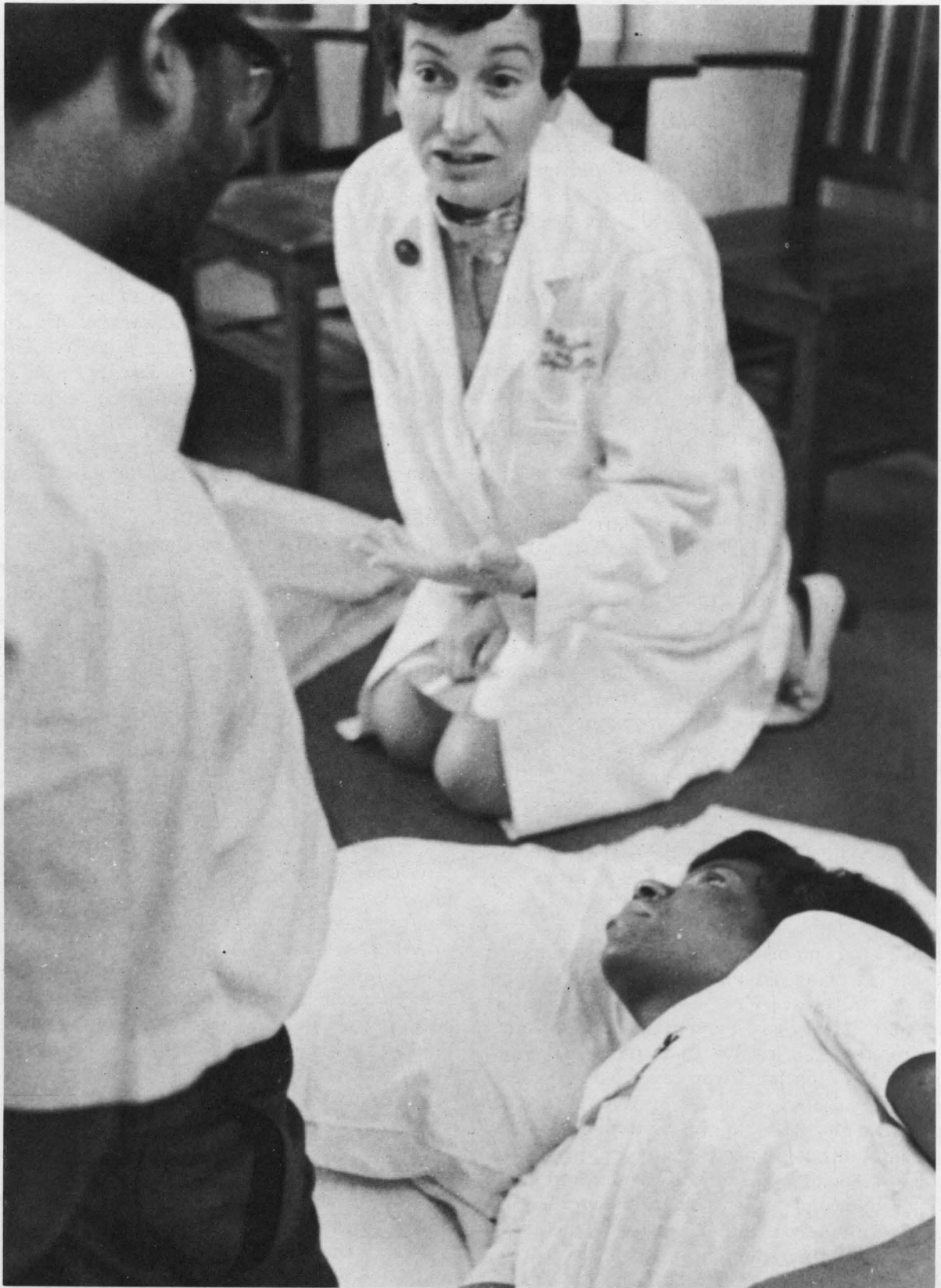
In the traditional practice of obstetrics, society's needs have been met by the individual obstetrician. Large clinics were a phenomenon of city hospitals which made major contributions to the teaching of obstetrics; but they were not the models for obstetric care for the country. Two events have changed this picture: the rapid increase in the urban population, especially in low income groups, and the changed reproductive patterns of Americans. As most obstetricians have seen, there has been a relative decrease in the birth rate of prosperous Americans with an increasing proportion of births occurring among poor Americans. Nowhere is this change more evident than in the discouraging position of America's infant mortality rate relative to that of Western Europe. For the past ten years our country's position has risen. Among prosperous Americans, the mortality rates are equal or superior to those reported in Western Europe; but the national rate is raised by the mortality and high proportion of premature births among the deprived.

The national picture is reflected in our own experience at Jefferson. In spite of a general decline in visits to other clinics, the maternity clinic has maintained a relatively constant number of service deliveries. In

asked frequently in the literature and they are by no means settled. Does prenatal care reach those who need it most? Are there aspects of our clinics which deter patients from using them? Do we need elaborate social support programs to improve not just the health of the mother but also the environment in which the baby will be born? Would changing the environment affect either the outcome of the pregnancy or the future performance of the child?

These questions directly challenge the goal of our outpatient clinic, namely to teach medical students and residents obstetrics by providing an excellent standard of care. Visits to the prenatal clinic clearly represent a unique opportunity for deprived people to obtain remedial social measures. But the physician's increased responsibilities in the clinic run counter to the trend to try to reduce his functions and thereby increase his productivity. Other programs, such as patient education, tend to compete with the physician for the patient's time. With the shortage of medical staff, these programs threaten the structure of the clinic which is organized exclusively around the patient's time with the doctor. The irony of the situation is that demands for social action are coming from the medical students themselves, the intended

Dr. Franklin, an Assistant Professor of Obstetrics and Gynecology at Jefferson, did his undergraduate work at Harvard and received his medical degree from Vanderbilt University. He is certified by the American Board of Obstetrics and Gynecology.



Dr. Ruth Wilf coaches a husband and wife in prenatal instruction class.

beneficiaries of the present service structure.

This has been the background of our obstetric service. A direct tie to a specific part of Philadelphia has not existed up to now because of Jefferson's location. Current federal programs, such as the Children and Youth Program, have been assigned to specific geographic areas and currently several neighborhood health centers are functioning or being planned. The availability of funds for these projects and the ties which existing projects have with other institutions put pressure on Jefferson to form an alliance with a specific section of the city.

Two years ago we surveyed our obstetric patients to find out who they were and why they came to Jefferson. Surprisingly, most of our patients have been to other hospitals (sixty-eight percent had delivered elsewhere) and the majority come from other parts of the city on transportation that passes other large teaching hospitals. Remarkably few patients come from South and Southwest Philadelphia where there are relatively few hospitals.

At the time of the survey, third party payments were readily available to low income mothers but only 21.5% of our patients were on public assistance. Slightly more than half of our patients (53.5%) were supported by the father of the baby. The remainder were either self-supporting or supported by family. The lack of support by the father of the baby (emotional and financial) has concerned many writers. In our clinic 69.5% of the patients described themselves as married but only forty-six percent were actually living with their husbands. This data reflected the national increase, particularly in urban areas, in births where only the mother was available to the child.

A substantial portion of the patients are teenagers, indicating the growing population of young people in the country and the accelerated life patterns of the poor. Sixty-four (thirty-two percent) of the patients surveyed were between twelve and nineteen years. Only a third of these patients were married.

Although our patients do not represent a specific community of the city, they do appear to divide themselves into communities of need. Teenaged girls have been shown to respond well both physically and emotionally to special social service programs carried out during their pregnancies. One of the best benefits of such a program was the reduction in subsequent pregnancies. A large number of patients who have been treated in the clinics or hospital conceive unplanned

and possibly unwanted pregnancies because of lack of attention to their family planning needs.

Financial support for restructuring the clinic to meet the needs of special groups of patients is available through the Maternal and Infant Care program. Patients qualify for the program according to their place of residence within the city, not on the basis of need. They must register for care by the second trimester of pregnancy. Currently Jefferson receives eleven dollars for every patient visit including two postpartum visits. This money includes the cost of medication and social service support. Through the program Jefferson has increased its social service and dietary support of the maternity clinic. Unfortunately, the mounting deficits of the Curtis Clinic have necessitated pooling incomes so that more elaborate programs for maternity patients have not been possible.

"barriers" to utilization

The administration of the clinic has tried hard to reduce what federal jargon calls "barriers to patient utilization." These are familiar to anyone who has dealt with a bureaucracy. In a clinic they can consist of numerous screening interviews to determine eligibility and costs, personnel who appear to be indifferent to the patients' needs, or confusing directions about places and times of appointments. While steady improvements have been made and while much of the credit for patient loyalty to our clinic is deserved by our clerical personnel, efforts to abolish a two and three hour wait on church pews have not been successful. Attendance at the clinic by the limiting factor, the physician, has had traditional low priority so that the physician's absence can defeat the best run appointment system.

A logical step in dealing with patients' wait is to accept it as a fact and use it for their benefit. For the past year and a half we have had a program of patient education for all mothers within eight weeks of their due date. This program has been directed by Dr. Ruth Wilf who holds a doctorate in embryology, but more importantly, has directed childbirth education programs in the Philadelphia area for a number of years. Using movies and videotapes (some of which have come from our own department), she has brought about a greater sense of participation by the patients in their own treatment. Several of our service patients have had their husbands present at the time of birth and have been very enthusiastic about the program. While the sessions cover the problems mentioned

above, a rigid structure has been avoided to permit the patients to determine their own interests and needs. In spite of the success of this program, it has not always fit smoothly into the doctor-centered structure of the clinic. Differences in attitude and philosophy become exposed quickly when information comes from several sources rather than a single authority. Since medical teaching is fundamentally authoritarian in nature, a potential conflict in the goals of the clinic has arisen. The solution is the one used in other comprehensive programs—to involve all concerned with the care of the patient in making decisions regarding the patient. Most of all, the patient herself should be involved.

Comprehensive planning for the future of each mother and child is essentially the task of the community, not of the teaching hospital. To improve the

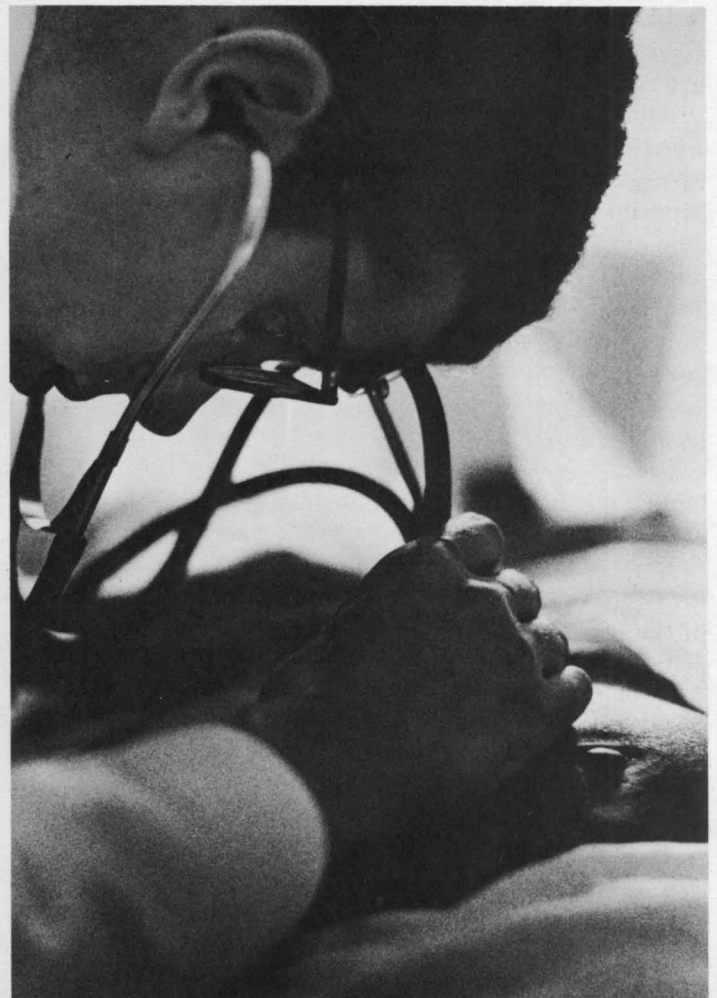
environment through pest and disease control, improved housing, better education and equal opportunity is clearly a responsibility shared by the individual and his social institutions. Pregnancy is a unique situation since it provides a time period of approximately six months in which the community and the health service can cooperate to do something about the total needs of the patient. If Jefferson is to involve itself in this way, the efficacy of some of its teaching may be weakened as risks are taken in political and social arenas that have been avoided previously. In short, we are at a crossroads. To maintain traditional programs may mean inadequate attention to our patients' medical and social needs and their subsequent loss to competing programs. But to engage in total support for our patients may require totally new concepts of the structure of the clinic and the role of the physician.



Dr. Franklin listens to Mrs. Paquita Hill translate the family planning wishes of a Spanish speaking patient.



Following experienced hands



... and learning of the unborn.

The Student Response

by Michael Steinberg, '70

Physicians in America, like priests and shamans everywhere, are conservative in two ways. Well established, relatively powerful, comfortably prosperous, they have been generally unreceptive to rapid societal change. But more important, society has consistently reinforced the conservatism of its healing classes. Rashness and radicalism, the innovative urge, have been deemed inappropriate and dangerous in those trusted with the sacred concerns of life, death, and suffering. Because the doctor is so often depended upon, he must, above all, be dependable. For nearly as often as science or art, it is faith that makes medicine work. And the physician, like the healer of the soul or of the spirit, must somehow be worthy of that faith.¹

Michael Michaelson, quoted above, has pointed to the origins of the role which society expects of its physicians. Because people have faith in his dependability and ability, the physician is responsible for performing his services accordingly. Adequate, hopefully excellent, health care is a right of all humans. And as much as it is a human right, it is a physician's obligation. The physician must investigate what services the people need and discover new ways to provide them as a part of this obligation; and the organizational structure in which the physician operates must strive to sensitize present and future physicians to the community's constantly changing needs. This involves arranging an educational program that prepares physicians to deal with these needs.

After the changes brought about by publication of the Flexner Report in 1910, medical education advanced very little. The need for change is apparent. One of the greatest failures of medical education has been its dehumanizing effect upon students. Some say that rather than going through the pre-clinical and clinical years, the medical student experiences the pre-cynical and cynical years. Men often enter medical school ready and willing to learn how to serve mankind. But an interesting, perhaps peculiar, thing happens. Through two years of pre-clinical training the qualities that are stressed are scientific inquisitiveness and academic excellence. Of course, this basic material must be learned. But throughout the

period there is little clinical correlation and no introduction to the environment and sociology of future patients. In the beginning of the clinical years, the student experiences some resurgence of his desire to serve, but he is often frustrated. Michaelson again succinctly describes the problem:

Today's revolution, of course, centers around the poor and the blacks, and around the ideas of justice and equality; in the field of health care the manifestations of injustice because of race or class are physically devastating and impossible to ignore. A student might be told, for instance, by an obstetrics resident that Negroes are too dumb to suffer post-partum depression; or he may watch an unconscious black man be labeled A.O.B. (alcohol on breath) by an emergency room physician and left to dry out before he is examined; or he may notice the difference between the way a white, middle-class mother ("You're a brave girl") and a black unwed mother ("Shut up and keep still") are delivered on the same table in the same hospital. He might wait six hours with a father and child in a hospital clinic only to be told, with them, to come back next week, and wait again. He might learn that a fifteen-year-old pregnant girl simply did not know about contraception, or prenatal care, or that iron was good for her, or even that babies come in nine months. Finally, many of the students who see these incidents begin to realize that they are not isolated occurrences, that to too great an extent they characterize American medicine, and to too great an extent they have been ignored by American medical education. The ideals and the realities of medical care seem suddenly disparate, suddenly to require a rapid and radical rapprochement.²

Students today have been awakened to the problems, and in some cases, the horrors, of our antiquated attitudes and methods of health care delivery. As a result of an increased sensitivity to the injustices present in our health care delivery system and an appreciation of the responsibility inherent in the profession, many medical students have become active proponents of change.



Medical student volunteers hear about community from Hezakah Thomas, a YGS Board member.

Here at Jefferson, the school administration has responded to the cries of the people, but at a slow, methodical pace. The school has established two center city community mental health centers, a mental health crisis unit at Philadelphia General Hospital, a Children and Youth Program for comprehensive care in a small area of South Philadelphia, and has moved toward motivating and training a small number of high school students in Jefferson labs. Those who are active at Jefferson and other medical schools are dissatisfied because the progress toward meeting the needs of the people has been too slow. As a result, they either have established projects dealing with these problems, or have aligned themselves with programs which are or seem to be meeting the needs of the people. Areas in which students are working include education and motivation of high school students, recruitment of minority group members for admission to Jefferson, organization of courses that expose the Jeff students to the needs of the urban community, and participation in new methods of health care delivery. I would like to emphasize that these students are not just protesting. They have found areas of the present system that they would like to change and have investigated improvements. And they are actually implementing their own new ideas.

dons program

In the spring of 1968, Cora Christian, class of 1971, attended a meeting at the Dean's office which dealt with black admissions. Her main concern was the scarcity of black faces in our classrooms, which was said to be due to the lack of qualified black applicants. The importance of motivating and educating potential physicians while they are still in high school was stressed. Cora took immediate action to help solve the problem. Upon contacting the Philadelphia Board of Education, she discovered that a Don Program existed in which high school students were being matched with students in college in an effort to motivate and familiarize them with careers such as engineering, teaching, and science. The Board of Education was investigating the possibility of participation by the medical school students of the city. Cora quickly gained the support of her classmates and started a Medical Don Program at Jefferson. Students from South and West Philadelphia High Schools and Overbrook and Benjamin Franklin High Schools were recommended by their schools' motivation offices. They were matched randomly with volunteers from Jefferson. The aim was that the student and his Don meet once a week for an hour or more, with a goal of ten to twelve meetings over a semester's time. In

some cases, enthusiasm fizzled, but in the majority, many rewarding hours were spent with the students. The format of the meetings was left up to each pair. Some discussed school problems, others worked on college and financial aid applications, and a few spent time at Jefferson doing scientific experiments or touring the labs and wards. A total of about seventy high school students and sixty medical students participated actively in the program last year. For this year, the outlook is bright. Close to fifty freshmen indicated interest at registration, and more than twenty showed up for the first meeting. The upper-classmen again have given their support. This year the Medical Dons had a raffle to raise funds so that the high school students can be reimbursed for travel expenses.

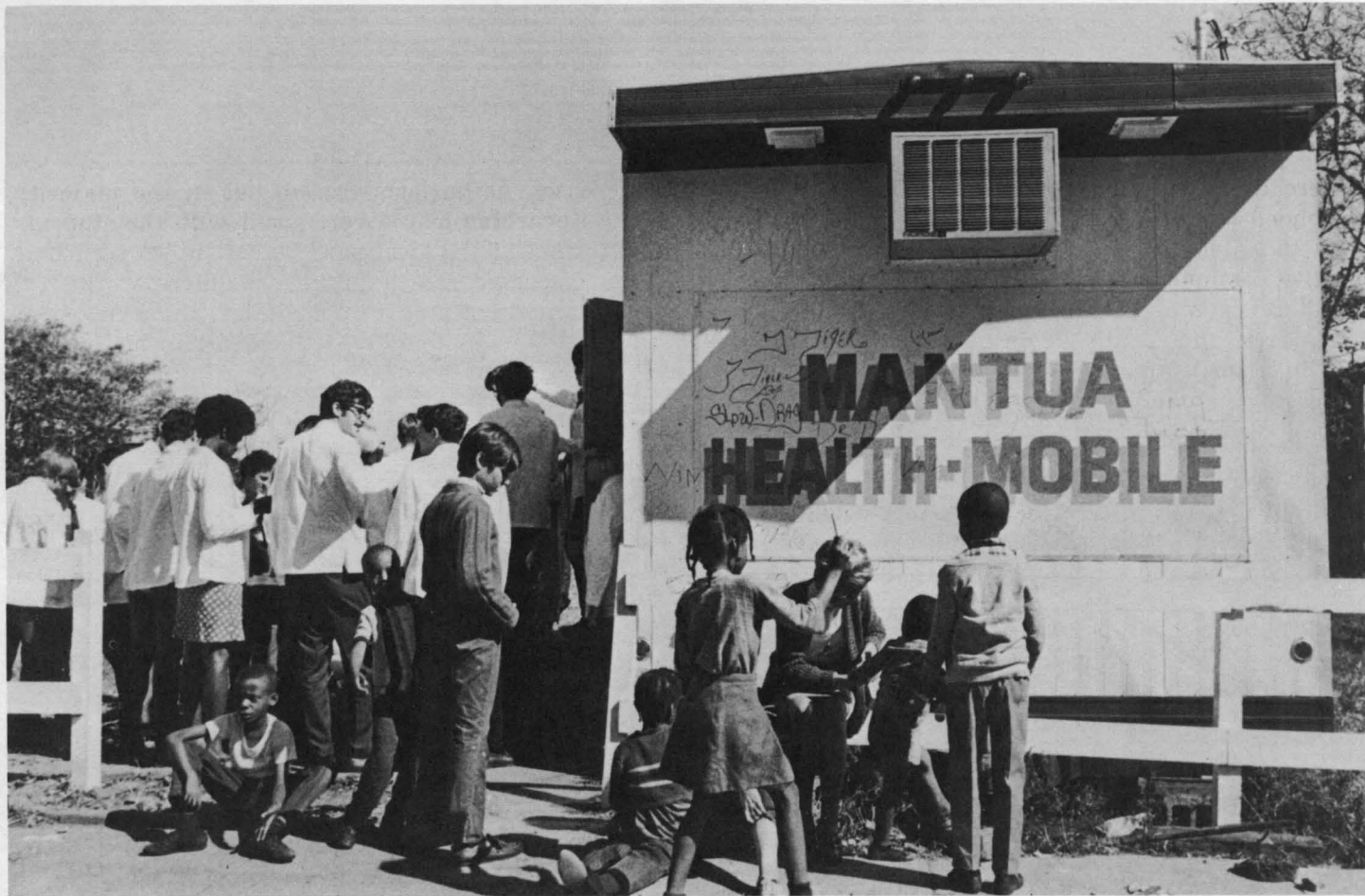
Presently Jefferson is in the process of negotiating a contract with South Philadelphia High School in which either fifteen or thirty high school students will be given science credit for working in labs at Jefferson for two or four hours a week. The students would gain the most, perhaps, if this program were joined with the already successful Don Program.

urban medicine

Another area of concern being addressed by students is in medical education. In our curriculum there is a complete absence of any material which would sensitize the students and faculty to the needs of our neighboring urban community. Last spring Jim Gerson, class of 1970, a faculty member and I discussed this huge gap in our education and decided to investigate what was going on in other medical schools. Recently the University of Pennsylvania and Temple University Medical Schools changed the names of their departments of preventive medicine to departments of community medicine. Not only were the names changed, but also the courses. Dr. William A. Steiger at Temple and Dr. William L. Kissick at Penn, Chairman of the respective community medicine departments, showed us course descriptions and discussed them with us. These schools are dealing with the very problems which are being neglected at Jefferson.

Drawing much from both programs, the students have taken action to alleviate the deficiency at Jefferson. We have organized a lecture-discussion series to begin in the winter quarter. Its goals are stated in this course description.

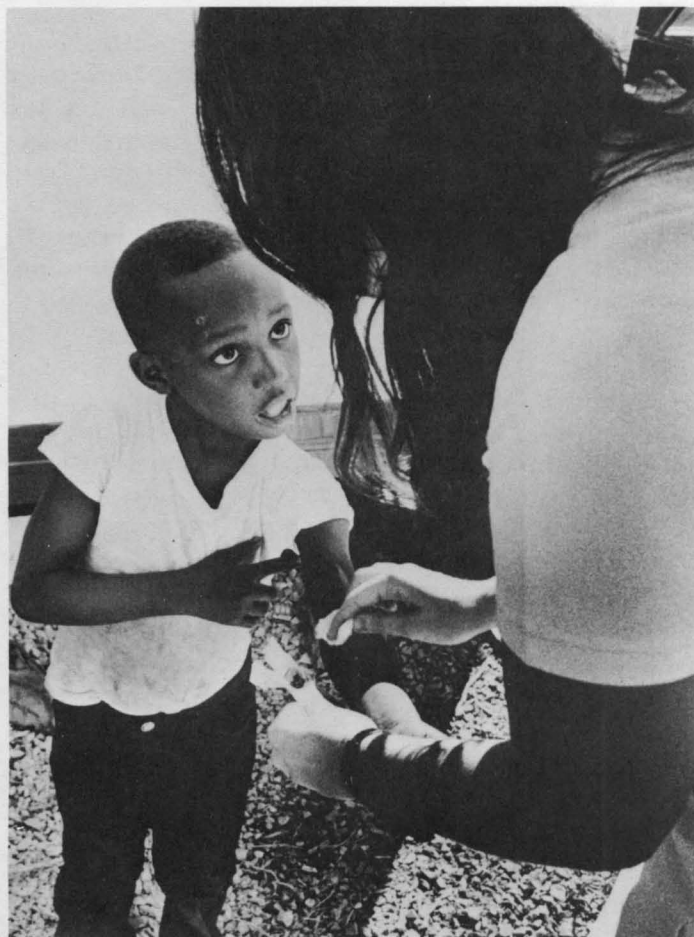
In an effort to alert our school, the faculty, and most important, the students, who will soon be the backbone of the medical community, we have undertaken to present a non-curricular lecture-discussion series dealing with urban medicine.



Last minute instructions are given at Healthmobile prior to making house calls.

Senior student, Mike Steinberg, with young lady friend.

"Will it hurt?"



We hope to investigate the rights of our urban neighbors and the nature of our responsibility to them. Recently, the question of whether medical care is a privilege or a right of all people has become a polarizing issue in the medical community. We unreservedly feel that health care is a right of all people and we feel obligated to resolve this issue in the minds of our fellow students and our faculty. We fear that if institutions and professionals continue to fail to become committed and involved in this problem, the consequences will nurture, if not provoke, violent social upheaval.

Most of the speakers for the course are from outside Jefferson. Some of the speakers we have invited or are in the process of inviting include: Dr. George Wald, Nobel laureate from Harvard; Dr. Benjamin Spock; Dr. Howard Levy, of Health PAC; Dr. H. Jack Geiger, head of Tufts Columbia Point and Mississippi Delta Projects; Rev. Paul Washington; Rev. James Woodruff; Mr. John Churchill, Director of the Freedom Library Day School. Proposed topics include: the sociology of the black man in America today; the welfare system; the white world from the black view; new health care delivery systems in the world, country, state and immediate area; black admissions and education.

The reception which the course received from the Dean's office was somewhat paradoxical — verbally cooperative, financially uncooperative, and on the whole, pessimistic. We were permitted to schedule our speakers at the convocation hour each Wednesday from one to two o'clock. We were given good wishes; but we were given no money for honorariums or the lecturer's travel expenses. After several months of fruitless investigation of financial sources, we were fortunate to discover the funds of the Jefferson Commons Cultural Committee. Its chairman, Aris Sophocles, class of 1970, recognizing the need, was able to back us partially from his fund for outside cultural lectures. Our goal is to provide vital information to the students, with the hope that our program will soon be included in the school's regular curriculum.

community health care

A new health care delivery system in which Jefferson and University of Pennsylvania medical students have become involved is the Young Great Society (YGS) Medical Services, Inc. YGS is an organization in Mantua, a black ghetto area of West Philadelphia with a population of 22,000. It was started by Herman Wrice several years ago to curb gang warfare in that

community. Since then YGS has expanded into many areas of self-help and neighborhood improvement. Mr. Wrice now heads the million dollar YGS Construction Company, working exclusively in Mantua and staffed entirely by residents of the area, many of them former gang members. A kindergarten, The Mini School, has been operating for two years now. A vector control unit has been working under the direction of Hezakiah Thomas, the preventive medicine ties of which are obvious. About one year ago William Spotwood convinced Mr. Wrice to convert one of the YGS's reconstructed houses into a medical center. Mr. Spotwood has been serving as Executive Director of the Center. In July of this year Dr. K. B. Gosnell, class of 1966 (see profile), joined the center as Medical Director. The Medical Center has been staffed to date by a full-time secretary, a full-time nurse, and volunteer physicians—practitioners and residents from Penn and Jeff. About a year ago YGS also began a Halfway House for heroin addicts. All therapy is on an outpatient basis and includes both methadone for the physical withdrawal symptoms and group therapy for psychological dependence. In September of this year, YGS was given a sixty foot long trailer converted into a "Healthmobile" for use as a satellite clinic and initial screening station.

An important concern in community projects in which medical students are involved is making sure that the people being treated receive excellent medical care, and that they are not being exploited for teaching purposes. Recently Harvard Medical School did an extensive study on the school's obligation to its surrounding neighborhood. One conclusion of the study called for the establishment of a clinic in the Roxbury section of Boston, not far from the medical school. Harvard started the clinic, but it was rejected by the neighborhood people. They felt that they were being used as guinea pigs, that Harvard was building and providing what it wanted, without asking the people what they wanted or needed.

YGS is creating what may be a prototype for neighborhood medical centers. Its organizational structure is composed almost completely of Mantua residents. In developing the various projects, YGS's first consideration is always the needs of these people in Mantua. All of these projects are created with a degree of flexibility, so that changing, or originally misinterpreted, needs of the community can be met. Proposals for grants and support for the various programs always include "no strings attached" clauses. Control of the medical services must and will remain in the hands of the neighborhood people and their leaders. Safeguarding the health rights of the

people of Mantua has been the foremost principle when allowing outside medical help into Mantua.

YGS Medical Services, Inc., is now in the process of forming an informal affiliation with the University of Pennsylvania School of Medicine. Residents, interns, and medical students will be permitted to take certain elective blocks at the various YGS projects. While working in Mantua, their activities will be directed by Dr. Gosnell and his staff. Penn will have minimal control, and will provide some medical expertise. Again, medical care must meet the needs of the people, and thus the mechanism for providing this care must be learned from the people and be directed by the people.

students and YGS

To date medical student involvement has been on a volunteer basis, and has been in three major areas. One of these is the house survey. On Saturday afternoons medical students, residents, nurses and practitioners from various specialties gather at the Medical Center for a briefing. The area to be surveyed that day is canvassed during the preceding day by community members. The medical students in groups of two go to the homes, take medical histories and do physical examinations and gather some sociological data. They refer sick people to the Medical Center or Healthmobile for a physical exam under a physician's guidance. Appropriate referrals are made to the specialists serving the medical center or to a doctor of the patient's choice. Baby shots are given on the spot to any children needing them. Nurses play an integral part by assisting in treatment, giving preventive medicine information, and doing follow-up on children receiving immunization series. The Mantua Healthmobile serves as the hub of the house survey. It houses physicians who are doing physicals, Pap smears, dental screening, pediatric exams and immunizations.

The narcotic rehabilitation program has treated over one thousand addicts since January. The initial rough estimates of follow-up statistics have been examined and have encouraged Dr. Gosnell to continue and perhaps broaden the program.

Student involvement is in two areas: taking histories and physicals of the addicts under a physician's guidance, and participation in group therapy sessions with the addicts. The leaders of each group are an ex-addict who has gone through the program successfully and a professional—a nurse, doctor or mental health worker. Once a week, all therapists meet with Dr. Jon Bjornson, Instructor of Psychiatry from Jefferson, who set up and runs the Philadelphia General

Hospital Mental Health Crisis Unit. Dr. Bjornson is a volunteer consultant to the addiction program. He reviews tape recordings of sessions with the therapists and gives instruction in group therapy techniques. A close association has developed with the therapists from Eagleville State Hospital, where there are regular group therapy technique sessions for the group leaders.

The Medical Center itself offers both medical and sociological experience for the medical student. The Center is set up like a typical clinic, but the big difference is the attitude of the staff. Volunteer doctors working at the clinic recognize that there is a tremendous communications gap between the patient and themselves. The physicians try to work within the value structure of the patient and avoid judging the patient in terms of their own mores. The doctors make an effort to show personal concern for the entire individual, trying not to be too efficient, but to listen and empathize. The physicians realize that frequently the patient's medical problem is firmly entwined in a socio-economic one. Only through an understanding of the entire person can the physician hope to provide the necessary recommendations and therapy. The aim, therefore, is to provide medical care with understanding of the total patient.

Students working at the Center are always under the guidance of a physician. Whenever the Center is open they can work as volunteers, or they can spend elective blocks there. Consideration is now being given to the possibility of having senior medical students sleep at the Center in an on-call room. They could see night time emergency cases, evaluate them, then call a physician to decide on disposition and the need for immediate therapy.

Student involvement in Mantua has been a rewarding experience for both the people and the students. Mantua is Penn's neighbor. The students and now the school are responding to its needs. Who and where are Jefferson's neighbors? Who is responding to their needs?

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²Ibid., p. 43.



Mantua Physician

"I decided to leave my residency on a Monday morning about seven or eight o'clock, after I went on rounds of homes where we had done immunizations the previous Saturday. The children I saw very desperately needed care of some type. In one home I visited, seven children were caring for themselves, some covered only with coats and huddled on the cushions of a sofa, sleeping. They weren't getting the most basic care. I could see the pathology of later life starting right there."

So in June, when Dr. Kermit B. Gosnell '66, completed the first year of his obstetrics and gynecology residency at Jefferson, he took a leave of absence—not without ruffling a few feathers at Jefferson in the process. "I saw a great deal that I could do to bring health care to the community; and that it would require more than a part-time effort," he reasoned. In the short space since June, as Director of the Young Great Society Medical Center, Director of the Drug Addiction Program, and President of the Board of Directors, he has become one of the community's most important leaders. The community is Mantua, a black ghetto in West Philadelphia. One of the top priorities of Mantua's 22,000 people should be health. But often day to day survival dictates otherwise.

Dr. Gosnell's initial visits to the homes in Mantua impressed him with the need for a day care center in the area. The only facility resembling this was run by the Young Great Society—and was essentially a first aid station. Working on this base, he expanded the Young Great Society Medical Center, which is in full time operation now with a permanent staff and a large volunteer contingent. The program has two facilities, one a Healthmobile, recently donated by the United Health Services. And YGS has expanded its services as well as its quarters.

The Drug Addiction Program, for instance, has been reoriented to a group approach. Its effectiveness is proven by the statistics. Only fourteen percent of addicts hold jobs in the general population. Eighty percent of them hold jobs after methadone maintenance. "Methadone maintenance is not ideal by any means," Dr. Gosnell concedes, "but it changes addicts into patients. Use of methadone may be a necessity, because the number of addicts who withdraw on a long term basis is very small. The socioeconomic conditions that initially force many people into addiction still exist."

Dr. Gosnell's approach to medicine is a pragmatic one. "I don't believe in the traditional mystique of the physician," he says. He finds nothing mysterious about medicine and nothing sacred about the physician's traditional relationship with his patient. Rather, he sees the patient as a consumer, deserving all the representation that consumers have in receiving other goods and services. "But the community has to be developed to the point where it can assert its rights," Dr. Gosnell believes. The danger of the patient being the forgotten man, in community health planning especially, is a very critical one. "Any community health program

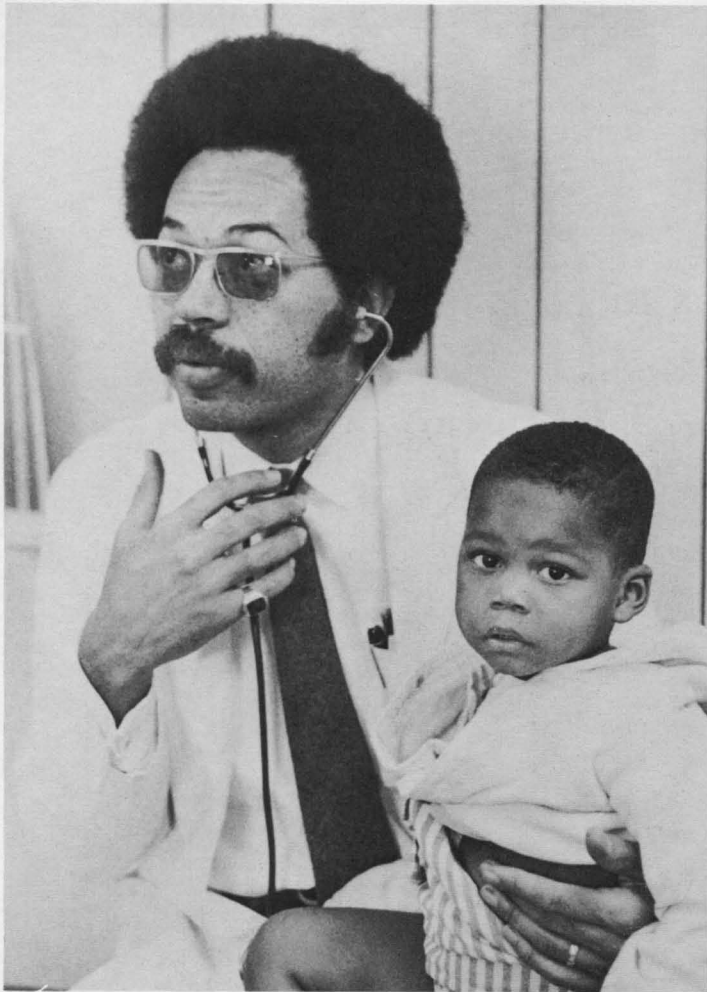
must involve the patients from day one. In designing a new system, you have to tell the community what you want to do, ask them what they need and what they will utilize. If the people can't relate to the center, they won't use it." The environment in which the care is delivered is important, too. "The typical physician's office puts the patient very much ill at ease." In the new YGS Medical Center building that is being designed, the "inner sanctum" aura of the classical office will be replaced by a new openness. The offices will have multipurpose use, so that the patient will have been familiar with it in less tense situations than a medical examination. The office will be closed only when patients are in there, so that the patient will know what he is getting into before he gets into it. Some greenery will add to the friendliness of the atmosphere.

Financing operations is a problem. "Gifts can't make it," the Director says. "We would like to have a cooperative program going eventually, with the adults in the community contributing a dollar and the children, fifty cents. We plan to make money in other ways too, for instance, leasing space in the new center, and hopefully, getting tax breaks for our volunteers. Government money can dry up at any time. We need a more reliable source." Dr. Gosnell does not pretend he has found a solution for the problems of community health on a national level. "Each community must design its own medical care program according to its own needs and resources." But he sees some priorities which should be common. "Medical services must be delivered to the community with the people involved having a controlling interest. And I believe the answer is a coordinated approach. One man giving service to the community is not the answer."

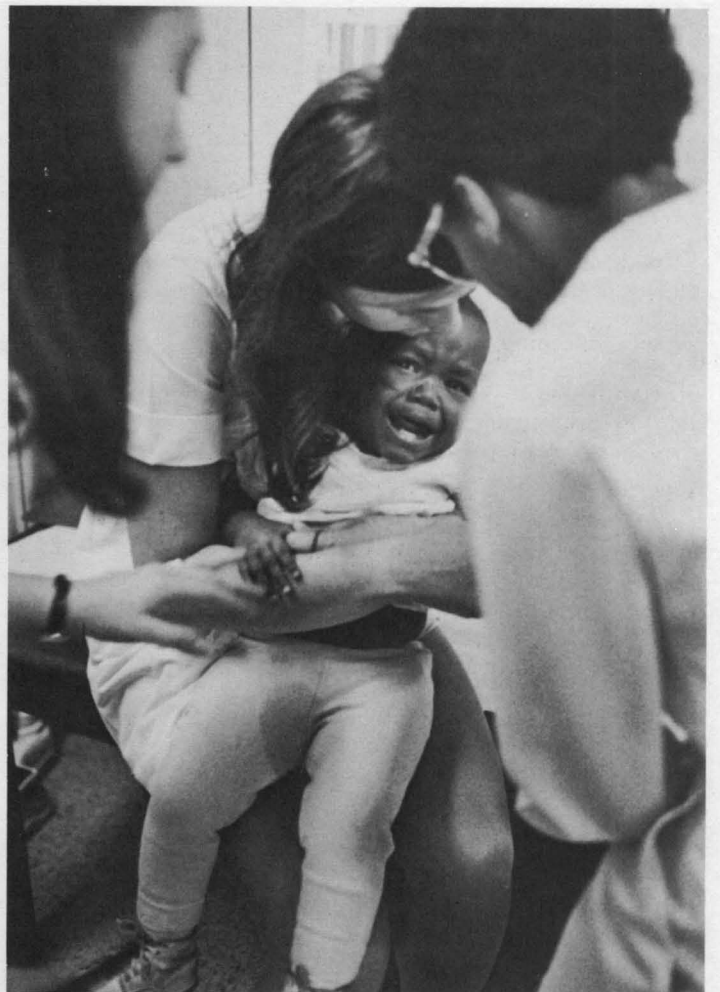
Dr. Gosnell is too busy coordinating the YGS medical programs to give all the care that the Mantua community needs. Besides seeing patients at the Medical Center, his daily schedule includes an average of four or five meetings. Often the last will be at his home, late in the evening. Before retiring he uses his study on the second floor of his West Philadelphia home to wind up the day's work. The day ends at 2 a.m.

The tangible rewards of Dr. Gosnell's job are less certain than they are for most physicians. The people, and the ability to provide for their needs to some degree, are rewards in themselves. "There is so much medicine to learn we are in danger of becoming technicians rather than medical men. Our specialization is leading us further and further away from the people. Of course, I realize that if you want a life for yourself, you have to become a subspecialist. But my criticism is that the general emphasis in medicine is not a personal enough emphasis. We all know how easily a patient becomes a case of hepatitis rather than Mary Jones with a case of hepatitis."

Bringing medical care where it is needed and lacking would be contribution enough; but Dr. Gosnell is delivering that care with the emphasis on the personal. And that has made all the difference.



Dr. Kermit B. Gosnell, '66, Director of the Young Great Society Medical Center.



Patients aren't always willing.



An on the spot treatment.



Two students visit a house in the Mantua area.

An illuminated "Emergencies" sign hangs over the driveway between Sansom and Walnut Streets. The passage will accommodate one vehicle. Sometimes it is an ambulance; most often it is a private car. It discharges its passenger directly in front of the Emergency door, which slides into the adjacent wall to admit him.

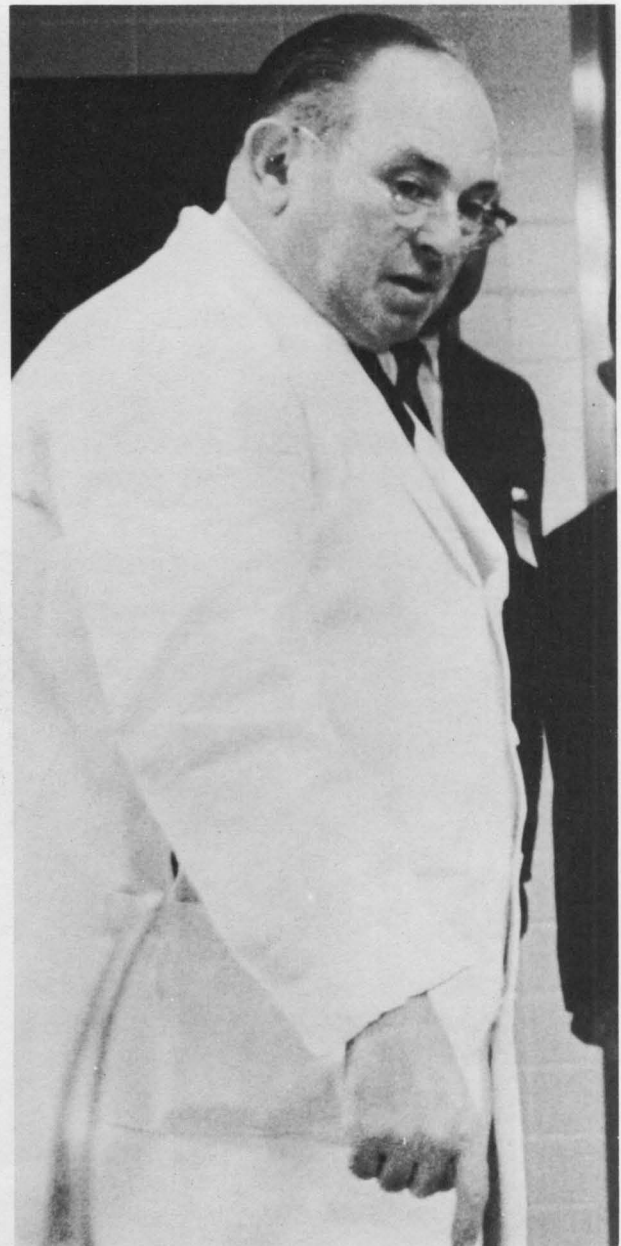
Inside, the passenger becomes a patient and very often has his first contact with the Jefferson complex. Based on his interaction here, then, he forms his opinions, not only of Jefferson, but also of the medical profession. Frequently for the adolescent, the primary source of medical care is the emergency department of the hospital. Thus, here he has his principal exposure to the medical profession.

The patient's needs may be urgent, and forty percent of the time they are, or they may be minor. The capacity of the Emergency Department to deal with either is equal. The Department's personnel can examine a patient, take a history, do laboratory work and have results immediately, x-ray and have results immediately or take an electrocardiogram and go to work on the findings. A specialist is accessible at all times. Twenty-four hours a day, the complete services of the Emergency Department are available to anyone who enters the door.

While their circumstances vary, all patients arrive at Jefferson's Emergency Department with a common motive: they need something. The man responsible for providing an organized response to that need is Dr. Joseph Keiserman. "We don't always recognize what these needs are," Dr. Keiserman admitted. "They aren't only medical, you see. They're sociological, psychological and economic too. The medical needs we can take care of," he said. "A pill, some oxygen or whatever. But what about a case like Mr. P.?" Dr. Keiserman was referring to a man who had visited the Department that morning for the third time in two weeks. Mr. P. wants to be admitted to the hospital; but there is no indication warranting admission. To prove that he is entitled to be hospitalized, Mr. P. has a habit of pulling out his Medicare card. "He's playing a game with us—and he's not even playing to win," says Dr. Keiserman. "You see, here is probably the only place he has interaction with other people. But," he sighed, "the Emergency Department can serve only medical needs, not all professional or personal needs. Contrasted with these needs are all kinds of wants, which are intermediate between needs and demands."

Dr. Keiserman's enthusiasm for the department's operation was easy to use. "We have an organization which is ideally suited to meeting the basic core health needs of the people." He was referring to the Department's in-depth service, its fully equipped facilities and its total flexibility. The total flexibility is the De-

An Emergency Department Meets a Community Need



Dr. Joseph Keiserman in Emergency Department.

partment's most important feature. "If anybody holders help, no matter what the hour, there is someone here to answer. We are the only out patient department that is completely operational twenty-four hours a day. Anyone who walks in that door receives our total attention and has access to our complete services." There was no doubt about the priorities held in the Accident Ward's routine. "People are the thing here. Every one of them is important." The purpose of this service is to render medical care "with dignity," as Dr. Keiserman puts it. "You hear people talk about the poor being subject to indignities in receiving medical and other services. Well, we make every effort to avoid that. They may have to wait because we give thorough examinations. People have to wait in private physicians' offices, though."

The Emergency Department treats about eighty patients a day. Some days as many as 120 cases come in. Every one is seen. They represent a range of economic and social levels, with the majority coming from the community immediately surrounding Jefferson. Whether the patient is receiving public assistance or residing in a neighboring high rise apartment house, there is no distinction in the service he receives. "We give more care to some people who come in here as non-paying patients than I could if they were my patients in a private practice."

At that point a student appeared at the door. "May I spend my lunch hour here?" "Of course," was the reply. "He wants patient contact," Dr. Keiserman explained. The popularity of the Emergency Department elective indicates that many students feel the same way. The fall term was booked by some eager students even before the elective cards were distributed.

The Director never forgets the important community relations role that his Department plays. Every letter from a patient is answered by him personally. He pulled out a folder from his file drawer. It was bulging with correspondence with patients. To letters of complaint, the reply would be more apologetic than defensive. Dr. Keiserman explores the reasons for any patient's dissatisfaction. The great majority of the letters commend the Department's efficiency.

As supersophisticated as is the hospital system of today, patients still expect the same solicitous care from the hospital personnel as the Christian Church nuns gave to patients in their hospitals before the middle ages. "Medical knowledge was minimal, diagnosis and therapy represented no cost, but the nuns would give their last piece of bread to a patient," Dr. Keiserman observed. Today hospitals are part of the modern world they serve; diagnosis cannot be made simply by looking at the skin or tongue and feeling the pulse. X-rays are expensive. Electrocardiograph machines represent a sizable investment and considerable maintenance cost. ECG chart paper is not given

by, but purchased from, a manufacturer. Laboratory techniques also depend on equipment and staff. Pharmaceutical costs are staggering. This leads to the matter of operational costs. In the face of a financial crisis, several Philadelphia hospitals were threatened with forced closure of their emergency departments last summer. The source of the difficulty was twofold: first, the City's allocation for indigent patients who are not covered by medical assistance programs, and second, a change of the Commonwealth program which would eliminate many medically indigent. As of this time the Commonwealth has restored its program to the previous level. A City ambulatory service contract (usually inadequate to cover the entire year's needs) which has some serious cuts written into it has not been completed as yet. The position expressed by Dr. Francis J. Sweeney, Hospital Director, has been that Jefferson Hospital will continue its emergency services as long as the patient load does not exceed the space and personnel capabilities, and as long as a grave financial crisis does not eventuate.

Many people who come to the Emergency Department have personal problems which have developed for good reasons, but which occasionally are reflected in a hostile manner. These problems are intensified by illness. Dr. Sweeney stresses the role of the Department in the community and recognizes that closure for any reason would only be interpreted as a denial of health services. Meanwhile the operational costs continue. Many cannot be explained simply as scientific, diagnostic or therapeutic expenses. "Take the case of a derelict in rags who walks in the door malnourished and intoxicated," Dr. Keiserman illustrated. "We take him into the examining room and lay him on white sheets, which are covered by jumping lice. Our nurses gown themselves, remove his clothes and burn them with his sheets. They bathe him. If it isn't a regular extermination day, the exterminator is called in to disinfect the room. We care for the guy until he's alright to go. Then we call Social Service and ask them to send down some clothes. And if it is approaching dinner time, we order a full course dinner for him, probably the only one he's had in a long time. Then he's on his way. He probably costs the hospital forty dollars by the time he leaves. The Emergency Department doesn't advertise these services, of course, because we don't receive any compensation for this kind of case and we could develop a regular clientele. But we never turn anyone away." Dr. Keiserman repeated: "You see each person is important here, whether he's a retired judge as we had last night, or a street sweeper, whether he's refined or belligerent and demanding. What each has to say about Jefferson is important. It's important for us to understand that what they see here is what they think of medicine as a profession."

The Physician as Administrator

by Norman M. Scott, Jr., M.D., '46

The modern physician takes better care of more patients than ever before. Although we are accused of compromising the art of medicine in order to accomplish this, surely no one would like to see a return to the horse and buggy days of home deliveries, office tonsillectomies, poltice, and purge.

Advances have occurred across the broad front of our profession. For better or for worse, new specialties have been born and old ones have fragmented into subspecialties. It is safe to estimate that ninety percent of the drugs listed in the pharmacopeia today were undreamed of when my father graduated from medical school in 1911. New and highly potent agents are becoming available faster than we can learn about the adverse reactions to the old ones. Open heart surgery and organ transplantation are only the more dramatic accomplishments of the surgeon-physiologist team. Many others, such as improvements in postoperative care, are equally important, though less newsworthy. Hospital design has become a recognized subspecialty of architecture. As a result, the modern hospital is a better, more efficient place to work, and a safer, more comfortable place in which to be sick—and much more expensive, too. Medical school curricula of necessity have been streamlined in order to accommodate more students and to better teach the growing mass of information these students must acquire. Graduates of the class of 1970 will take for granted such wonders as cardiac catheterization, multichannel autoanalyzers, cine-fluoroscopy, fiberoptic endoscopy, and intensive care wards equipped with electronic monitors and recorders. Computers are already speeding up literature reviews and assisting with the financial aspects and supply problems of hospital management. The near future will see computers used to store and cross-reference individual clinical records, for research, and for quick retrieval.

These changes have paralleled major social and technological changes and great population growth in our country. Medicine, in its broad sense, is "big business," one of the biggest in America. Medical care is expensive, especially if hospitalization is required, and there are problems of distribution and cost which have long interested both state and federal politicians.

Federal funds provided under the Hill-Burton Act are assisting local communities with the construction of new hospitals all over the country. The Food and Drug Administration has been given increasing authority in the quality control of drugs. Medicare offers almost free medical care to all Americans over the age of sixty-five. Whether we as physicians like it or not, federal interest in what we do and how we do it is here to stay, and further legislative control of our profession is sure to come.

These changes in the complexity, scope and cost of medicine have resulted in major alterations in many established medical organizations. Hospitals, medical schools, life insurance companies, research institutes, clinics, drug manufacturers, federal health agencies, such as the Public Health Service, and the medical services of our armed forces all have expanded in response to the challenges which those changes have engendered. Solo practice is becoming less popular. Today's medical graduates are forming partnerships, joining groups and clinics, and making careers in full-time hospital practice, research, and teaching. Many of these medical organizations need full-time physician-administrators. The solo practitioner, the partnership, and the smaller medical group can, of course, function well without such leadership, although they often employ accountants to assist

them with the purely business and tax aspects of their operations. The small community hospital usually is managed efficiently by a full-time non-physician hospital administrator, who receives guidance from a chief of staff. However, there are many organizations which, because of their size and the multiplicity of their functions, need a full-time physician-administrator, as well as a business manager. Surely a general hospital, especially if it has teaching and research programs, needs such an individual. State and national medical societies also must have full-time executive directors, selected from the ranks of practicing physicians. Drug manufacturers, the medical departments of insurance companies, research institutes, federal agencies, the Public Health Service, and the medical services of our armed forces all require physician-administrators at every level of their organizations.

What are the prerequisites for the good physician-administrator? First of all, he should have a solid clinical background, preferably with certification by one of the American Boards. Whatever his administrative role, he must maintain an active interest in his chosen professional field and save time for patients, and perhaps for teaching or research. There are many analogous situations. For example, an airline will run better if its president is a licensed pilot who has done some flying himself and can still handle an aircraft in an acceptable manner. Employees of the airline, especially the pilots, will respect him and his decisions, because they know that he understands their problems—he is one of them. Medical organizations are no different.

Second, our physician-administrator must have a practical appreciation for the importance, indeed the absolute necessity, of the application of good management practices to all phases of our profession. The solo practitioner, partnership, and the small medical group may function well, perhaps, with only the assistance of a good public accountant. Larger medical organizations cannot function well without using modern management principals and techniques. Complex fiscal and tax matters, purchasing and contracting, labor relations, public information problems, personnel affairs, and many others are all part of the daily operation of any large medical organization. Few physicians are equipped or inclined to participate effectively in the details of such purely administrative and managerial functions. These functions therefore must be handled by laymen who are experts in those fields.

If lay administrators are to apply modern management and administrative techniques effectively, they need the guidance and cooperation of the physician-administrator who must retain control over and responsibility for the entire operation. The physician-administrator thus is a vital link between the practicing physician and the lay administrator. He must understand and have faced personally the problems of the former, and appreciate the importance of the contributions of the latter.

One of the greatest problems in medicine today is the shortage of young physicians who are interested in careers as physician-administrators. This is understandable. How can we expect a man to endure the rigors of medical school, internship and several years of residency, and then, after surviving the ordeal of his American Board examinations, do anything but full-time professional work? The answer is to publicize the importance of the role of the physician-administrator, and convince more young men that such work can be both stimulating and professionally rewarding.

Only by retaining executive and administrative control through such physician-administrators can we as physicians hope to realize for America the full potential of the scientific progress we have made, and at the same time preserve the essential traditions of the past.

profiles



Dr. Faber instructs the patient's mother.

There is a prevailing *joie de vivre* about Kalman Faber. And it isn't just the jaunty demeanor that conveys it. The *joie* is in his approach to his work, his patients, to people. His work is pediatrics, and his patients, of course, children. "They're the best part about pediatrics," Dr. Faber quips.

No wonder children like Kalman Faber; he likes them. His approach to his work gives the patient his fullest attention and energies (which are considerable) full time. *Any* time. "Treating the patient in pediatrics includes the mother and the father too," he says. With a walk into Dr. Faber's offices it becomes obvious that parents like the way Kalman Faber cares for their children. The walls are lined with thank you tokens, such as children's paintings and rhymes. And there is an occasional special tribute, like the one hanging in the examining room: a cartoon sketch of the Peanuts gang unanimously voicing, "You're a good man, Dr. Faber." Dr. Faber doesn't think he deserves the plaudits. "Most kids get better by themselves. It's the nature of children and the nature of childhood diseases." The fact that pediatrics encompasses more than children, though, is an aspect he enjoys. "I like being the family doctor—the one the family calls to ask, 'What doctor shall we call? Dad is having a gall bladder problem.'" You establish a rapport with patients and families over the years. You can win their confidence if you understand their growth and development."

This is the kind of personal involvement and total commitment to the patient that Dr. Faber finds

essential in medicine. The lack of this physician involvement is a defect that he sees in more socialized medical care programs. "It's the lack of total commitment of the physician—the nine to five sort of attitude that I can't go along with." People are going to have to be acclimated to this approach, however, he feels. "They're going to get better overall care this way—even though they won't see the same doctor all the time." But the Faber approach is different. "For me, even if my wife were giving birth, if I had a sick patient, I'd be with that patient because that's where I belong." It's that kind of attitude that has made Kalman Faber what amounts to the doctor's doctor for pediatrics at Jefferson.

Dr. Faber has been at Jefferson ever since he left his native Canada in 1946. A graduate of the University of Toronto, he came as Jefferson's first official pediatrics resident, under the urging of Dr. William T. Lemmon, now Emeritus Professor of Surgery, and the late Dr. Thomas A. Shallow, who was the Samuel D. Gross Professor of Surgery. He didn't intend to stay past the residency. Twenty-two years later he has one of the busiest pediatrics practices in Philadelphia.

He could have let it go at that. But a few years ago, Dr. Faber got the feeling that he was living a pretty fat life. So he decided to take a venture into the community beyond Philadelphia. Into Niagara, for instance; or Ceylon. "One of my colleagues introduced me to the idea of the S.S. HOPE. I felt I had to contribute something, and at the same time I could learn."

Dr. Faber now takes a ten week trip with HOPE every year. (Except in 1967, when a broken leg—from a skating board accident—prevented his tour.) Dr. Faber was also motivated by the fact that he had something to contribute. “Pediatrics is totally preventive medicine. And there is no preventive medicine at all in the countries I’ve visited. They have no concept of the overall growth of the child, emotional and intellectual growth especially. I’ve seen whole wards filled with tetanus and diphtheria patients.” The primary job of HOPE is teaching native medical personnel, and in teaching, treating disease. HOPE leaves a land force in the countries it visits and staffs these facilities with its own personnel even after the ship’s departure. “For instance, if a native comes on board with a premature baby, he wants to keep it on board, of course. HOPE’s approach is to say, ‘Let’s go back to where you live and make a facility where this baby can be treated—right in your own community.’”

Whatever resentment the native physicians might have felt at the government’s inviting HOPE to the country was soon forgotten when a HOPE doctor could pick up a sick baby and make it well. “People have all kinds of ideas about Americans, but when they see you give yourself freely, these ideas change,” Dr. Faber observed. “I think it is America’s best, absolute best, means of communication with underprivileged countries. Wherever it has gone it has conquered—with love.”

That’s the sort of thing you might say about Kalman Faber too.



“Reflexes seem fine.”

faculty notes

administration

Dr. Joseph S. Gonnella, Associate Dean, was a member of the faculty for the Association for Hospital Medical Education, 1969 Fall Learning Institute, which was held in Denver, Colo., during September.

medicine

Dr. Harold L. Israel, Clinical Professor of Medicine, spoke on "Sarcoidosis and Aspergilloma" at the Brompton Hospital in London on June 24; and at the British Tuberculosis Association Annual Conference in Cambridge, England, on June 26, he discussed "Effects of Prednisone, Chlorambucil and Methotrexate in Sarcoidosis."

Dr. Farid I. Haurani, Associate Professor of Medicine, has returned from his sabbatical leave. During his year abroad he spent six months as Visiting Professor at the American University of Beirut, and six months as Research Associate with Professor Bernard Halpern of College de France in Paris, working on the reticuloendothelial system and erythropoiesis.

Eleven papers by members of the Sarcoidosis Clinic at Jefferson were presented at the Fifth International Conference on Sarcoidosis held in Prague, Czechoslovakia, June 17-21.

neurology

Dr. Leonard Graziani, Professor of Neurology and Professor of Pediatrics, has received a National Institutes of Health grant for \$71,635 to study the electroencephalographic activity of infants receiving treatment in the Intensive Care Nursery of the Hospital.

Dr. Nathan S. Schlezinger, Clinical Professor of Neurology, spoke on myasthenia gravis in Honolulu, Bangkok, Delhi and Athens during a world tour in June. He also spoke on clinical neuro-ophthalmology in Honolulu and in several oriental countries. While in Honolulu Dr. Schlezinger reviewed new developments at Jefferson during a special dinner meeting of the Hawaiian chapter of the Jefferson Medical College Alumni Association.

Dr. Robert L. Calmes and Dr. Leonard Katz, who completed their residencies in neurology at Jefferson this year, have been awarded United States Public Health Service Fellowships to be held at Jefferson. Dr. Calmes will be studying evoked potentials under the direction of Dr. Roger Q. Cracco, Associate in Neurology, and Dr. Katz will be studying the physiological maturation of the central nervous system in neonates, under the direction of Dr. Leonard Graziani.

obstetrics and gynecology

Dr. Abraham E. Rakoff, Professor of Obstetrics and Gynecology and Professor of Medicine, made the following presentations at the American College of Obstetricians and Gynecologists District 8 meeting in Albuquerque, N. M., during September; "Menstrual Disorders of the Adolescent," "The Management of Hirsutism and Acne with an Androgen Antagonist," "Hormonology of the Placenta," and "Psychoendocrine Mechanisms in Endocrinology."

ophthalmology

Dr. William C. Frayer, Professor of Ophthalmology and Professor of Pathology, conducted a course in Ocular Pathology at the Lancaster Course in Ophthalmology, Waterville, Me., held during June and July.

Dr. Thomas Behrendt, Associate Professor of Ophthalmology, presented an exhibit at the International Symposium on Fluorescein Angiography, held June 8-14 in Albi, France. The title of the exhibit was "Fluorescein and Spectral Reflectance." He also presented four papers.

Dr. Edwin U. Keates, Associate in Ophthalmology, was an examiner for the American Board of Ophthalmology examinations on June 1.

pathology

Dr. Robert L. Breckenridge, Associate Professor of Pathology, and at Our Lady of Lourdes Hospital in Camden, N. J., Director of Clinical Laboratories, was one of four pathologists elected to the Board of Governors of the College of American Pathologists at the organization's annual meeting held in Chicago during September.

Dr. Leonard E. Reisman, Associate Professor of Pathology and Associate Professor of Pediatrics, presented a paper entitled "Chromosome Mosaicism in Congenital Defects" at the Third International Conference on Congenital Malformation at the Hague, The Netherlands, on September 12.

Dr. Eileen Randall, Assistant Professor of Pathology and Assistant Professor of Microbiology, spoke on "Comparison of Two Commercially Available Blood Culture Flasks" at the annual meeting of the American Society of Microbiology, held in May at Miami Beach, Fla.

Dr. Heinz G. Schwartz, Assistant Professor of Pathology, attended the Twelfth International Congress of Clinical Chemistry in Geneva, Switzerland, in September, and presented a paper entitled "Immunoelectrophoresis on Acetate Membranes."

Dr. William V. Harrer, Associate in Pathology, attended the Seventh International Congress of Clinical Pathology in Montreal, Canada, on July 14, and gave a talk on "Metastatic Carcinomatous Involvement to the Heart and Symptoms."

pediatrics

Dr. Robert L. Brent, Professor of Pediatrics and Chairman of the Department, participated in the Third International Conference on Congenital Malformations at The Hague, The Netherlands, September 6-13, and gave a paper on "Implications of Experimental Teratology." He also chaired the sessions and gave introductory talks on "Medicolegal Aspects of Congenital Malformations."

Dr. Herbert C. Mansmann, Jr., Professor of Pediatrics, was co-author of a paper presented at the fall meeting of the American Society for Pharmacology and Experimental Therapeutics held in Pittsburgh during August. The paper was "The Effect of Acidosis on the Response of Tracheal Smooth Muscle to Aminophylline and Acetylcholine." "The Need for Controlled Ventilation" was the topic for a seminar at the 1969 Scientific Session of the Pennsylvania Medical Society given by Dr. Mansmann on September 15.

pharmacology

Dr. Julius M. Coon, Professor of Pharmacology and Chairman of the Department, was Chairman of the Thirteenth Session of the Joint FAO/WHO Expert Committee on Food Additives, held at the headquarters of the Food and Agriculture Organization of the United Nations in Rome, May 27 to June 4.

preventive medicine

Dr. Heinrich Brieger, Honorary Professor of Preventive Medicine, has been appointed Chairman of the Board of a project sponsored by the National Library of Medicine and executed by the University of Pennsylvania. The title of the project is "Chemically Oriented Toxicology Information System."

psychiatry

Dr. Baldwin L. Keyes, Emeritus Professor of Psychiatry, was master of ceremonies and made a presentation address in the name of Dr. Kenneth E. Appel, the recipient of the Malvern Award for 1969, at the Malvern Dinner at the Treadway Inn, Oct. 30.

Dr. Floyd S. Cornelison, Professor of Psychiatry and Chairman of the Department, was appointed a member of the Editorial Board of *Medical Insight*.

Dr. Daniel Lieberman, Professor of Psychiatry,

served as Chairman of a symposium on "The Systems Approach as a Basis of Community Mental Health," at the American Psychological Association convention, held in Washington, D.C. during September.

Dr. Robert S. Garber, Visiting Associate Professor of Psychiatry, has been elected a delegate for psychiatric hospitals in the American Hospital Association's House of Delegates. At the Association's convention held in Chicago during August, he discussed the paper "Psychiatric Hospitals in the Modern Health Complex." He presented a paper titled "The Medical Practitioner, the Psychiatrist and the Community" at the Southern Psychiatric Association convention held in Asheville, N. C., October 5 to 8.

Dr. Kurt Wolff, Associate Professor of Psychiatry, presented a paper "Depression and Suicide in the Geriatric Patient" at the Eighth International Congress of Gerontology in Washington, D. C., August 26.

Dr. James L. Framo, Associate in Psychiatry, presented a paper on "The Family Transactional Approach as a Central Integrative Model for Community Mental Health Services" at the American Psychological Association convention.

Dr. Doris Willig, Clinical Associate in Psychiatry, delivered a paper on "The Therapeutic Implications of Non-verbal Communication in Physical Recreation with Emotionally Disturbed Children" at the Second International Congress of Social Psychiatry, held in London in August.

radiology

Dr. Robert L. Brent, Professor of Radiology and Professor of Pediatrics, recently was appointed a Consultant to the Food and Drug Administration at the federal level. He also has been named Associate Editor of the Journal, *Teratology*, and is a member of the Editorial Board of *Current Contents*.

Dr. Peter Dure-Smith, until recently a Kodak Traveling Scholar from England, has joined the Department of Radiology as a permanent member of its staff.

urology

Dr. Paul D. Zimskind, Nathan Lewis Hatfield Professor of Urology and Chairman of the Department, and Dr. J. Louis Wilkerson, Associate in Urology, were awarded the Certificate of Merit by the Medical Society of New Jersey at the 203rd Annual Meeting of the Society, held in Atlantic City, N. J., recently. Their exhibit was titled "Clinical Use of Silicone Rubber Ureteral Splint Tubes Inserted Cystoscopically."

the jefferson scene

146th session

The Jefferson Medical College of Thomas Jefferson University began its 146th academic year on September 8. There are 192 students in the new freshman class, one of the largest classes in Jefferson history. Responding to the growing needs for physicians throughout the country, Jefferson last year increased substantially the number of students accepted for admission to the freshman class. The class of 1973 includes nineteen women and twenty-eight students in the Penn State Jefferson Accelerated Program. Seventeen of these new medical students are children of alumni.

Opening Exercises were held in McClellan Hall. President Peter A. Herbut, M.D., the main speaker, recapitulated highlights of Jefferson history, reviewed some of its recent past, spoke of its present and commented briefly on its future. He noted "that as history records Jefferson's primary mission from its very inception has been the production of physicians. This is still its near all consuming interest. But times and circumstances do change and have changed. What was once almost solely the Art of Medicine has now become the Art and Science of Medicine."

President Herbut continued by telling the capacity audience that as a natural evolvement of the past years Jefferson has now attained the status of University. As a component of the University, a School of Allied Health Sciences has been developed. Also the Jefferson School of Graduate Studies will be expanded and reorganized into the College of Graduate Studies with its own Dean and separate budget. The School of Allied Health Sciences eventually will offer courses which are not part of the present curriculum.

On speaking of this curriculum Doctor Herbut said "our intention is to supply only those disciplines

that are necessary for the specific education and the specific degree in question."

The President also noted that in June 1969 Jefferson graduated its 21,319th physician, a total unsurpassed by any other medical school in the United States and added, "But numbers of graduates alone do not make a first class medical school. Quality is the essence! And in this respect Jefferson has never taken a back seat to any institution.

In addition to the President other speakers included Chairman of the Board James M. Large, Dean William F. Kellow Associate Dean Samuel S. Conly (representing the graduate school), and Dean John W. Goldschmidt.

affiliation

An affiliation with Mercy Catholic Medical Center will provide increased facilities for clinical training of Jefferson medical students. The seniors will receive training at the Medical Center's Fitzgerald Mercy division in suburban Darby, Pa., and the Misericordia division in West Philadelphia. The hospitals' departments of medicine, surgery, obstetrics and gynecology and pediatrics will participate.

short procedure unit

Jefferson has installed a new service that, in some cases, eliminates the in patient and board charges from the patient's hospital bill. The "Short Procedure Unit" is the first of its kind in the Philadelphia area and only the third to be established in the country. The Unit handles treatment or short operative procedures that require no more than eight hours in the hospital for completion. The full range of hospital facilities will be available to patients registered in the Short Procedure Unit, but they will not be official hospital in patients. The criteria for using the Unit are that the treatment can best be done in a hospital and can be completed within eight hours. At the end of eight hours, if the doctor decides that the

patient is not ready for discharge he is admitted as an in patient.

Dr. Charles W. Semisch III, Clinical Associate Professor of Medicine, is responsible for the development of the plan. He estimates that five percent of the persons now handled as in patients could be treated in the Short Procedure Unit, making more beds available. He also pointed out that at a Massachusetts hospital where a similar unit is in use, the number of operating room visits has increased twenty percent, but no increase in staff has been necessary. Also, while the usual waiting period for an in patient bed at the same hospital is ten to fourteen days, it is less than a day for the short procedure unit.

Patients in the Short Procedure Unit will be charged the usual rates for use of operating room facilities, drugs and supplies, plus an hourly service charge. Their laboratory charges are reduced. Blue Cross, Intercounty Hospitalization and Medicare have indicated their willingness to cover services to Short Procedure Unit patients at the same level at which they would cover in patients. Dr. Semisch added that, in the long run, having this type of service is going to help keep down rates of hospital insurance, as these have been going up because hospital costs have risen.

appointments

Dr. Edward R. Burka, Associate Professor of Medicine at Jefferson, has been appointed Director of the Blood Bank at the hospital. Dr. Burka has been associated with the Cardeza Foundation for hematology research at Jefferson since 1966. He is a graduate of Princeton University and the College of Physicians and Surgeons, Columbia University.

Dr. Burka recently received a \$217,000 grant from the Public Health Service to continue his research on factors controlling the rate of protein synthesis and nucleic acid metabolism in red blood cells and their effect on aging and maturation of these cells.

class notes

1897

Dr. Forrest J. Bovard, 2088 Mandeville Canyon Rd., Los Angeles, Calif., celebrated his ninety-fifth birthday on July 14. The town of Tionesta, where he spends his summer months, marked the occasion with a large newspaper spread. Dr. Bovard practiced there for sixty years, until his retirement five years ago. Walking is one of Dr. Bovard's most enjoyable pastimes. **Dr. Victor G. Heiser**, who resides at Manhattan House, Apt. B-1601, 200 E. 66th St., New York City, celebrated his ninety-sixth last spring.

1914

Dr. Jesse G. Webster, 45 Main St., Wellsboro, Pa., has retired after more than fifty years of practice in and around the Wellsboro area. Dr. Webster was one of the first members of the staff of the Soldiers and Sailors Memorial Hospital in Wellsboro. Dr. Webster relaxes by working in his garden, and also has to his credit building a cottage.

1919

Dr. Milton B. Emanuel, 625 Vine St., Philadelphia, was honored by his classmates at the fiftieth reunion in June with special tributes to his role in keeping the class of 1919 together. The plaudits embarrassed Dr. Emanuel, who replied that whatever efforts he has devoted to Jefferson and the class of 1919 were more than rewarded by the class' appreciation. The crowd at the reunion came from all parts of the country and each was given a chance to tell what he had been doing.



Dr. Ronald Moore, '19, with certificate from Pennsylvania Medical Society for fifty years of medical service.

CAREER COUNSELING

A new service
sponsored by
the Alumni Association
in conjunction with
the Dean's Office

Inquiries regarding post graduate education, practice opportunities, available residencies, special surgical techniques, review of basic sciences or other related subjects may be forwarded to the Alumni Office. Faculty in appropriate departments will provide counsel.

Dr. Frank B. Marsh, 713 Barker St., Salisbury, N. C., was recently invited to become a member of the "Fifty Year Club," an organization which recognizes members of the Medical Society of North Carolina who have practiced for at least fifty years. Dr. Marsh serves on the staff of Rowan Memorial Hospital. He played a large part in construction of a new hospital building after a fire destroyed the original in 1934.

1920

Dr. Jaime de la Guardia, Apartado 5473, San Jose, Costa Rica, has been retired for the last four years and is enjoying the climate in San Jose (3,600 feet above sea level). He intends to travel extensively, and in August took off on a two months trip to Europe. He plans on coming to Jeff for the 50th reunion.

1924

Dr. Samuel S. Shapiro, 1412 N. Fourth St., Philadelphia, has been doing some traveling—recently returned from an anesthesiology seminar in Japan and Hong Kong.

1928

Dr. Vane M. Hoge, 4004 Everett St., Kensington, Md., has decided to "call it quits" and retire after forty-one years "in harness."

Dr. Jack A. Rudolph, 9999 N.E. 2nd Ave., Miami, Fla., is on the mend now after suffering a coronary followed by a stormy convalescence.

1929

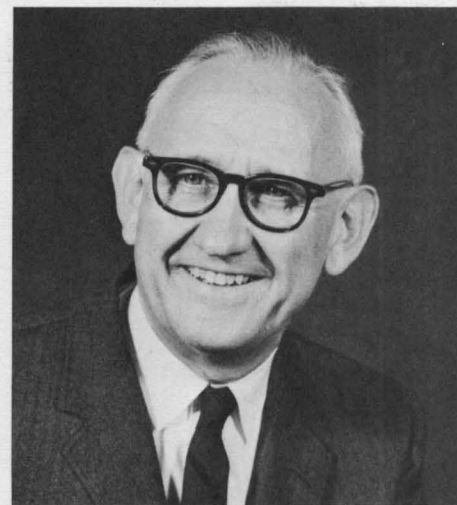
Dr. Robert A. Houston, V. A. Hospital, Lebanon, Pa., was presented with a distinguished service medal and citation by the American Legion, Department of Pennsylvania, at the American Legion's state con-

class notes

vention in July. Dr. Houston has been Chief, Medical Service, at the Lebanon Veterans Administration Hospital since 1948.

1934

Dr. Joseph A. Hesch has been appointed to the newly-created position of Medical Director of the Mercy Catholic Medical Center of Southeastern Pennsylvania. The Medical Center was formed by the recent merger of Fitzgerald Mercy Hospital in Darby, a



Dr. Hesch

suburb of Philadelphia, and Misericordia Hospital in West Philadelphia. Dr. Hesch has served as Director of Medical Education at Misericordia and as Medical Director of the Pediatrics Division. He also has been Director of Pediatrics at Fitzgerald Mercy. He is a Diplomate of the American Board of Pediatrics and a Fellow of the American Academy of Pediatrics.

1936

Dr. Elmer M. Reed, Ritenour Health Center, Pennsylvania State University, University Park, Pa., has joined the staff at Ritenour after twenty-two years of ENT practice in Burlington, Vt. He was Assistant Professor of Otolaryngology at the University of Vermont College of Medicine. Dr. Reed is certified by the American Board of Otolaryngology and is a member of the American Academy of Ophthalmology and Otolaryngology.

1937

Dr. Bernard B. Zamostien, 4801 N. Ninth St., Philadelphia, is President of the Pennsylvania Academy of General Practice. The Academy is composed of 1,500 family physicians practicing in Pennsylvania. It is



Dr. Zamostien

the only medical organization that requires continuing postgraduate education and study as a requirement for continuing membership. Dr. Zamostien has been President of the Academy's Philadelphia Chapter, a member of the Board of Directors and Chairman of the Committee on Hospitals and the Committee on Graduate and Undergraduate Education, and treasurer of the Academy. He is on the staffs of Germantown and Albert Einstein Medical Center hospitals.

1938

Dr. Clarence Cohn, 1174 Ash, Winnetka, Ill., has received the Chicago Dietetic Association's Award of the Year. Dr. Cohn, Director of the Division of Nutritional Sciences at Michael Reese Hospital and Medical Center, has been working on studies of food metabolism. He is an Associate Professor of Clinical Pathology at Chicago Medical School.

Dr. George A. Silver, former Deputy Assistant Secretary of Health, has been named Professor of Public Health at the Yale School of Medicine. Dr. Silver is an authority on urban health problems and on designing and administering family health care programs. He resigned his position with the Department of Health, Education and Welfare in 1968 to join the Urban Coalition as Executive Associate, responsible for program planning in health matters.

1939

Dr. Paul A. Kennedy, 530 El Camino Real, Burlingame, Calif., is Assistant Clinical Professor of Surgery at Stanford University Medical School.

1942

Dr. Francis A. Deitmaring, 7922 Hudson Blvd., N. Bergen, N. J., is President of the North Hudson Physicians Society.



Dr. Kinsey

1943

Dr. Frank R. Kinsey, Ridgewood, Lewistown, Pa., is serving as President of the Pennsylvania Radiological Society, a chapter of the American College of Radiology. The Society has approximately 700 members in Pennsylvania. Dr. Kinsey also has been elected President of the Medical Staff at Lewistown Hospital, where he has been Chief of the Department of Radiology for twenty years.

Dr. Louis H. Palmer, Jr., has been re-elected President of the Staff at Bryn Mawr Hospital, Bryn Mawr, Pa. He has been with Bryn Mawr since 1945. **Dr. Edward J. Murphy J'44**, 1129 Ashbridge Rd., Rosemont, was elected Vice President of the Staff.

1944J

Dr. Maxwell Steel, Jr., 6800 Bock Rd., Washington, D. C., was promoted to the rank of Brigadier General during ceremonies held at Andrews Air Force Base in August. Dr. Steel is Command Surgeon of Headquarters Command, USAF, Washington, D. C., and Commander of the Medical Center at Andrews.

1945

Dr. Richard D. Bauer, 2513 Bucklodge Rd., Adelphi, Hyattsville, Md., has been named President of the Prince George's General Hospital Medical Staff. Dr. Bauer is a past President of the Medical and Chirurgical Faculty of the State of Maryland and the Prince George's County Medical Society.

1946

Dr. Robert E. Sass, 912 E. State St., Sharon, Pa., is serving as President of the Northwestern Pennsylvania Chapter, American College of Surgeons. He is also head of the Mercer County Medical Society. Before

coming to Sharon in 1954, Dr. Sass was associated with the Lahey Clinic in Boston, Mass.

1947

Dr. Leo J. Corazza, Hazleton Heights, Hazleton, Pa., has been appointed Chief of Medicine at the Hazleton State General Hospital.

(See next page.)

1948

Dr. Ellis L. Silberman, 4048 Sapphire Dr., Encino, Calif., after thirteen years as Associate Director of Diagnostic Radiology at Cedars of Lebanon Hospital in Los Angeles, has opened a private practice of radiology.

(See page 45 for reunion report.)

1949

Dr. Henry M. Perry, 706 N. Davis St., Bloomfield, Iowa, has been re-elected President of the Medical Staff at Davis County Hospital in Bloomfield. He also has been appointed County Chairman of the Davis County, Iowa, American Cancer Society crusade.

Dr. Sheldon Rudansky, 520 Franklin Ave., Garden City, N. Y., is President of the Brooklyn-Long Island Urologic Society.

1950

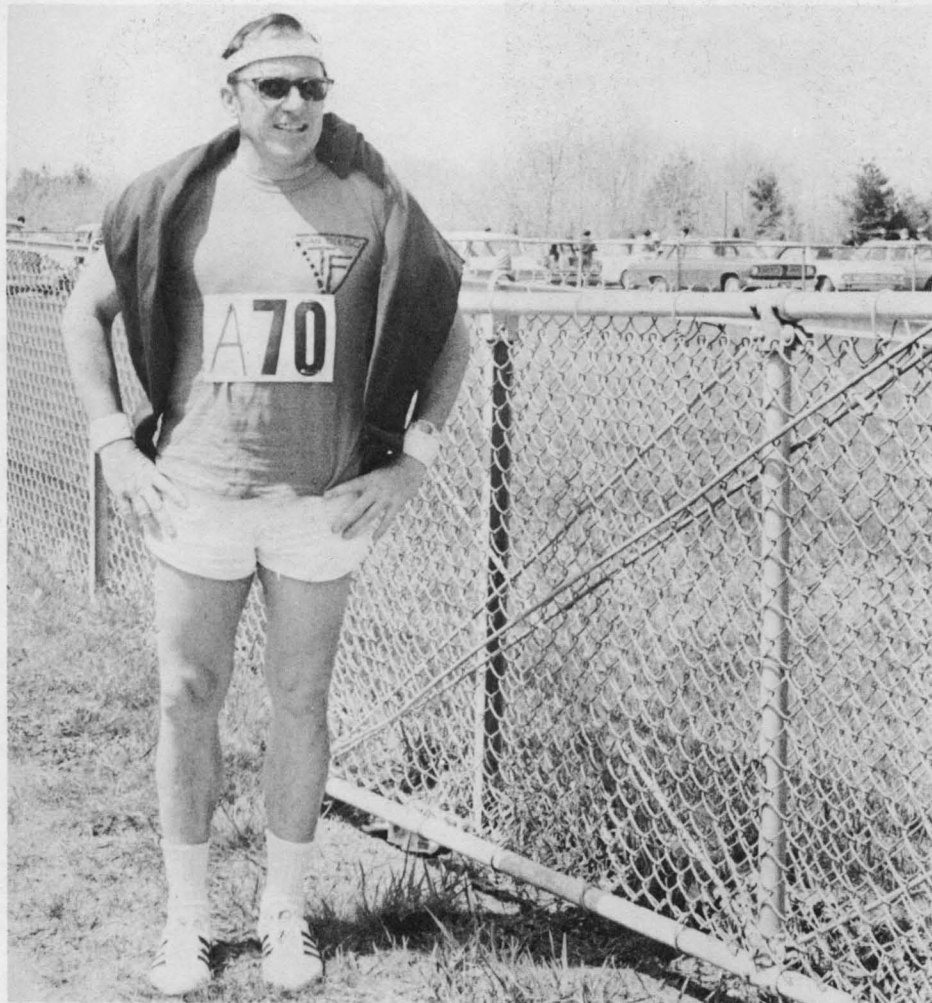
Dr. Herbert A. Yantes, 4761 Griscom St., Philadelphia, has been appointed President of the Medical Staff of Frankford Hospital. Dr. Yantes has been with Frankford for nearly twenty years and is currently Chief of Medicine there. He is also on the faculty at Jefferson.

1951

Dr. Glen Ebersole, 35 Sunset Ave., Lakewood, N. Y., practices radiology with three associates in Jamestown, N. Y., and is active in the Buffalo Radiological Society and the County Medical Society. The Ebersoles are finding western New York state very agreeable, particularly the skiing, sailing, fishing and golf. "Helen is back in college obtaining an M.A. in history, with hopes of teaching college later."

Dr. Leonard S. Girsh, #113 E. Church Rd., Philadelphia, presided, as President, at the Twenty-first annual meeting of the Pennsylvania Allergy Association, held in Hershey, Pa. He is Assistant Professor of Internal Medicine at Temple University Medical Center and Director of the Allergy Department at St. Christopher's Hospital for Children and Children's Heart Hospital of Philadelphia.

Dr. Robert G. Hale, 4004 Fairway Rd., Lafayette Hill, Pa., is President-elect of the Pennsylvania Academy of General Practice. He has been a member of the Academy Board of Directors and Vice Speaker of its



Dr. Herrick at start of "the great race," the Boston Marathon.

THE GREAT RACE

William Herrick had never run a race in his life when he entered the Boston Marathon this year. The bug set in last January when he felt the need for more exercise. He'd done some running before and decided to do it that way.

At first the five-in-the-morning rising time and the black silence of the winter streets at that hour made it an effort to persist. But as the sun rose and the air warmed, it became his favorite time of day.

Dr. Herrick first heard about the Boston Marathon while talking to a physician friend who had run in it. The seventy-year-old race is called for each Patriot's Day in Boston. Anyone is eligible to match his stamina and skill with the best runners in the world. It took Dr. Herrick only a minute to decide to get in shape for it. He mapped out his schedule. Within a month he was running ten miles a day, in two parts. On weekends he'd try longer runs, up to sixteen and twenty-two miles. After about nine miles he would take water and Gatorade.

The day came closer and "butterflies" were setting in. Before departure for Boston on April 19, Dr. Herrick had a physical examination and was declared in excellent shape. No excuses for dropping out now! In Boston, he drove over the course the day before the race, all twenty-six miles of it, from the quiet country town of Hopkinton to the Prudential Plaza in downtown Boston. The night before the "Great Race," the runner couldn't get to sleep until 4 a.m. Up at 5:45, he was off to the running. William Herrick was tagged A-70, and was one of 1,333 participants that day. The gun sounded and the rubbershod feet burst from the starting line. They passed Ashland, Framingham and Natick, where Dr. Herrick's wife, Billie, handed him some Gatorade as he ran by. Wellesley College girls came out to cheer the runners as they went through the town. All along the way well-wishers offered water and orange slices to the runners. After about eighteen miles some were beginning to fall by the wayside. By the time Dr. Herrick reached the twenty-one miles mark, his legs pained. Finally, nearly five hours from the time he set out, the welcome sight of the finish line; and then, complete exhaustion.

Dr. Herrick finished approximately 800th. No world records were set, but finishing standing up and running was enough satisfaction for this enthusiast.

SODAT

Dr. Leonard (Pat) Rosen's community concern has effected a change in Chester, Pennsylvania. It was about a year ago when he first became aware of the prevalence of drug abuse among teenagers in the city. One youth he treated died of kidney damage. He had been inhaling carbon tetrachloride fumes as a substitute for sniffing glue. The youth's death was followed by a few more cases where the cause of death was drug abuse. Dr. Rosen did a little exploring and discovered the lack of facilities in the community to deal with this problem. He decided to do something about it. He sounded out other community members and found an equal concern on their part. Dr. Rosen visited drug abuse treatment centers. He talked with addicts and to those who treated them. He surveyed the extent of the problem in Chester and found the results alarming.

Dr. Rosen is largely responsible for revealing the drug abuse problem in the Chester community. His proposals to take action and to found a center for treatment of drug abuse met mixed reactions. But with his characteristic dynamism, he moved to mobilize all the resources he could to attack the problem. The forces grew, and SODAT, Society to Overcome Drug Abuse among Teenagers, was formed to do just that. Facilities for the rehabilitation efforts were donated and SODAT was in business.

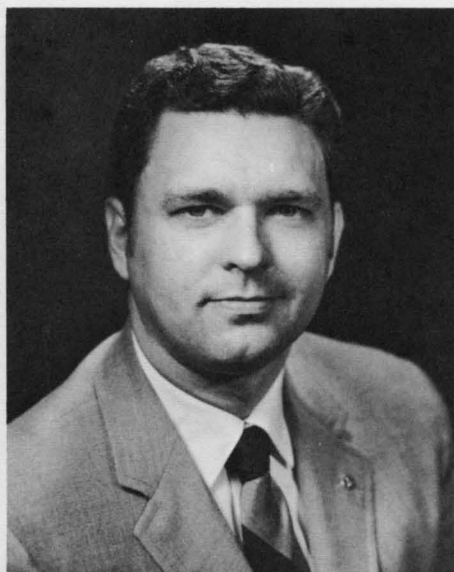
The program is geared to treat pre-addict drug problems. The chief tool is group treatment, where small groups of addicts and former addicts try to work with emotional and mental problems through discussion—open and honest discussion. Ex-addicts are the best means of reaching the potential or actual addict, Dr. Rosen says. They "know what it's all about" and can discuss it as no one else can. The participants are encouraged to talk about the problems they usually conceal. Through this communication the human ties that are necessary for a stable personality can be established. The groups abide by certain rules of conduct and are encouraged to take responsibilities at the Center. Participants have the opportunity to develop social, vocational and creative skills in an atmosphere where they feel they "belong." A non-residential program of therapy, the participants meet for at least several hours a week.

SODAT's purpose is also to alert the community at large to the drug abuse problem. Dr. Rosen's efforts have been effective in this regard, as the schools have now adopted a program of drug abuse instruction.

Dr. Rosen is aware of the impossibility of being one hundred percent effective in eliminating the drug problem among teenagers. With the establishment of the Center, and the dangers of drug abuse being taught in schools, he feels that important steps have been taken. Dr. Rosen's steps have motivated a community and mobilized its resources.



Dr. Beers



Dr. Woutersz



Dr. Magee

House of Delegates. He will be installed as President next year.

Dr. Verne L. Smith, Jr., 45 Pine St., Danvers, Mass., gave up his private general practice in April 1968 to join a five-man group covering the Emergency Room of the Lynn Hospital, Lynn, Mass., on a full-time basis.

1952

Dr. Howard Fugate, Jr., Box 141, R. D. #2, Punxsutawney, Pa., has returned to Punxsutawney to practice internal medicine. He previously had a practice in Morristown, N. J., and decided he wanted to be a "country doctor."

Dr. Stanley Q. West, Jr., opened a general practice at 221 S. Main St., Jersey Shore, Pa., in July. Dr. West moved his practice here from Philadelphia.

1953

Dr. David W. Kulp, 1518 Old Gulph Rd., Villanova, Pa., has been appointed to the staff of Pottstown Mental Health Center as a child psychiatrist. He is also child psychiatrist at the Pathway School in Norristown, Pa., and was formerly Medical Director of the Lancaster Guidance Clinic.

Dr. John M. Levinson, 1708 Talley Rd., Forest Hills Pk., Wilmington, Del., visited South Vietnam last spring, for the sixth time since 1963. This year, as last, he served as the medical consultant to Senator Edward M. Kennedy's committee on refugees and civilian war casualties.

Dr. Raymond P. Seckinger, 210 N. 17th St., Allentown, Pa., has received a postgraduate degree from New York State University. Dr. Seckinger completed a two year specialty training program in analytic group psychotherapy.

Dr. Fredrick S. Wilson, 1338 Jericho Rd., Abington, Pa., in now employed by McNeil Laboratories as Director of Clinical Investigation. Dr. Wilson is an Elder in the Abington (Pa.) Presbyterian Church.

1954

Dr. Norris B. Groves, 102 S. Maple Ave., Martinsburg, W. Va., is Medical Director of the new General Motors plant located in his area. As well as keeping up his practice, he is busy with civic affairs. He is President of the Rotary and the Retarded Children Association, and holds a board position with the Red Cross.

Dr. Pierce D. Samuels is now a resident psychiatrist with Allentown State Hospital, Allentown, Pa. Dr. Samuels and his wife were commissioned as medical missionaries in 1955. They served in East Pakistan before Dr. Samuels began his residency.

Dr. Raymond M. Wargovich, 911 Huey St., McKeesport, Pa., has been appointed plant physician in the Medical Department at the Homestead Works of U. S. Steel. Dr. Wargovich served twenty-seven years in the Navy and is Senior Medical Officer at the Naval Training Center at McKeesport.

1955

Dr. Elwood C. Rosenblatt, 271 Buckner Ave., Haddonfield, has joined the Princeton Hospital staff, with privileges in allergy in the Department of Medicine.

1956

Dr. Kenneth N. Beers, a former member of the medical support team for Apollo astronauts, is now on duty at Ubon Royal Thai AFB, Thailand. Dr. Beers is Director of Base Medical Services at the northeast Thai installation and primarily supports person-

nel of the F-4 Phantom fighter-bomber Eighth Tactical Fighter Wing. Dr. Beers came to Southeast Asia from the Manned Spacecraft Center in Houston, Tex., where he was an Air Force member of the National Aeronautics and Space Administration staff for five years. Dr. Beers participated in the Gemini program and helped develop bio-instrumentation and biomedical systems used to check the physical well-being of astronauts in space during his assignment at Houston. During Apollo II, he was a medical advisor on the monitoring staff at the Mission Control Center.

Dr. Wallace T. Miller, 3105 Coulter St., Philadelphia, has been promoted to Associate Professor of Radiology at the University of Pennsylvania School of Medicine. Dr. Miller has been in the Radiology Department there since 1957.

Dr. Theodore B. Woutersz, 821 Malin Rd., Ithan, Newtown Square, Pa., has been appointed to the medical staff at Wyeth Laboratories in Radnor, Pa. Before joining Wyeth, Dr. Woutersz was an associate in obstetrics and gynecology at Harrisburg Polyclinic Hospital.

1957

Dr. Donald P. Elliott, 70 Eudora St., Denver, Colo., was made a Fellow of the American College of Surgeons in October of last year. He has had a private thoracic and cardiovascular surgery practice in Denver since 1966.

Dr. John T. Magee, Clemson Rd., Bryn Mawr, Pa., has been appointed Director of the Department of Medicine at Bryn Mawr Hospital. Dr. Magee has been a member of the Bryn Mawr staff for six years and was named Director of Medical Education there in 1966. He has served as Assistant Attending Physician to the internal medicine service and also did his internship and residency at Bryn Mawr.

Dr. Lowell D. Mann, 306 S. Market St., Elizabethtown, Pa., has returned from India after serving as director of a mission hospital there for ten years, and has joined an associate in general practice.

1958

Dr. William W. Clements, 517 Tory Hill Rd., Devon, Pa., a general practitioner, has been appointed to the medical staff at Paoli Memorial Hospital. Dr. Clements is also on the staff of Bryn Mawr Hospital, Pa., where he served his residency.

Dr. Robert A. Cooper, Jr., a Professor of Pathology at the University of Rochester, has been named Associate Dean for Curricular Affairs there. Dr. Cooper was with the University of Oregon before coming to Rochester.

Dr. Edward Fine, 271 Moore Lane, Had-donfield, N. J. has become a Diplomate of the American College of Obstetricians and Gynecologists.

Dr. Hilbert E. Oskin, 105 Laurie St., Jeffer-son Highlands, Pittsburgh, Pa., has opened an office for the practice of general psy-chiatry with an associate. Dr. Oskin is Clinical Instructor in Psychiatry at the Western Psychiatric Institute in Pittsburgh, where he served his residency.

Dr. Lloyd G. Plummer, 318 Main St., Latrobe, Pa., has opened an office to practice ob-gyn in Latrobe. Dr. Plummer returned to Latrobe after four years of practice in Troy, Ohio.

1959

Dr. Vincent P. Blue, 2 Glenn Terr., Haver-town, Pa., started a solo internal medicine

and allergy practice last July. He is on the staffs of Misericordia, Riddle and Fitzgerald Mercy Hospitals, and is an Instructor in Medicine at the Hospital of the University of Pennsylvania. Last November the Blues had their fifth child.

Dr. Ronald E. Cohn, 4940 Frankford Ave., Philadelphia, has been appointed Medical Director of Frankford Hospital. He is the first full-time Director in the history of the hospital. Dr. Cohn has a residency in obstetrics and gynecology and is certified in internal medicine as well. He is on the faculty at Jefferson.

Dr. Murray Feingold, 20 Ash St., Boston, Mass., has collaborated in the preparation of *Atlas of Mental Retardation Syndromes*, intended to aid physicians in visually diagnos-ing conditions which suggest mental retardation in infants and children of abnormal appearance. The work was supported and published by the Division of Mental Retar-dation, Social and Rehabilitation Service of the U. S. Department of Health, Education and Welfare. Dr. Feingold is Assistant Pro-fessor of Pediatrics at Tufts University School of Medicine and Chief of Pediatric Ambulatory Services at Tufts-New England Medical Center. He is also Director of the Center of Genetic Counseling and Birth Defect Evaluation, which is sponsored by the National Foundation.

Dr. Sandy A. Furey has been appointed to the newly-created position of Director of Medical Services at Moses Taylor Hospital, Scranton, Pa. Some of his responsibilities include administration of the Department of Medicine and the new Coronary Care Unit at the Hospital. Dr. Furey previously

practiced internal medicine and cardiology in Scranton.

Dr. William E. Ryan is studying arthritis and rheumatic diseases under a fellowship at the Mayo Clinic, Rochester, Minn. He recently completed two years of general internal medicine residency at Jefferson.

Dr. Samuel L. Stover, University of Ala-bama, 1919 Seventh Ave., South, Birming-ham, Ala., has been appointed Assistant Professor of Pediatrics and Assistant Pro-fessor of Physical Medicine and Rehabilita-tion at the Medical College of Alabama. His primary responsibility will be the devel-opment of a new pediatric rehabilitation program at the Spain Rehabilitation Center of the University of Alabama. Dr. Stover has served in Indonesia and Jordan, his work supported by the Mennonite Central Com-mittee. He also has been Medical Director for the Children's Seashore House, a pedi-atric convalescent and rehabilitation hospital in Atlantic City, N. J.

Dr. James R. Wiant, Mt. Kipp, Glen Gardner, N. J., is in South Vietnam serving the civilian population with the American Medical Association Volunteer Physicians for Vietnam. Of Vietnam's 1,000 physicians, 700 are in military service and not available for fulltime civilian practice. At home, he serves as Assistant Medical Director at New Jersey State Sanatorium in Glen Gardner.

1960

Dr. Harold J. Kobb, 74 Windham Way, Freehold, N. J., has been named Acting Medical Director at the State Hospital at Marlboro. Dr. Kobb joined the State Hos-pital in 1966 and was appointed Chief of Medicine in 1968.

REUNION REPORT—class of 1948

The now famous (and at times infa-mous) class of 1948 once again sounded the tribal drums for the annual re-union. The message was loud and clear and was received with great enthusi-asm in the hills of West Virginia and on the patios of the Main Line. As a result, the loyal members of the class of 1948 once again gathered, this time not beneath the palms of Bermuda, nor the shadows of the mint juleps of the Greenbriar, but on the banks of the Schuylkill River, within sight of Jeffer-son Hall and in the depths of the sand traps surrounding the City of Brotherly Love. Thus on the weekend of the twentieth of June 1969, another chap-ter was written in the glorious history of these outstanding gentlemen of Jef-ferson.

Jim and Betty Mae Kessel were the first to arrive at the Marriott Motel having endured the 1,586 mile trip

from Ripley, West Virginia. Close be-hind was Ted Lancaster (from the town of the same name), defending champion of the Class Golf Trophy. Ted arrived with his own caddy and professional score keeper. Unlike Rudy DePersia, who had trouble getting out of Bermuda, Ted had trouble getting into Philadelphia, for he had brought his own golf cart and was unable to get it through the toll gate at the Valley Forge exit of the Pennsylvania Turn-pike. By Friday evening a sufficient number of champions had arrived and cocktails and dinner were enjoyed by all at L'Auberge in Spread Eagle Vil-lage in Wayne.

At 8 a.m. (yes, 8 a.m.) on Saturday the twenty-first of June, John Atkinson cleared the fairways (in the interest of safety) at Llanerch Country Club and the Annual Class of 1948 Golf Tourna-ment was underway. Using the Stein-metz System and following in the great tradition of the class golfing greats, i.e., Moyer, Fingo, Hughes and Peterson (and numerous others who prefer to remain nameless), the annual contest ended in a four-way tie. However, un-

like the mid-ocean course in Bermuda, Llanerch claimed no life or limb but only seventeen golf balls which was a new low for this annual occasion.

The sorrow, cheating and profanities of the day were quickly forgotten when the clan gathered for cocktails Satur-day evening at Eden Hall in Villanova. John and Dorothy Kohl arrived with an old gentleman called George from Val-ley Forge, while Jim and Eileen Daly arrived by helicopter. Arlene and Daniel Shaw, John and Eve Atkinson, Ted and Ginny Lancaster, Jim and Betty Mae Kessel and Cathy and Norm Quinn arrived by more conventional means. The highlight of the reunion was a dinner-dance at Overbrook Coun-try Club, which was arranged and hosted by Dan Shaw. Even Dr. John McCormack of the class of 1935 was present and joined the Mexican Hat Dance.

As darkness became less intense and it was again necessary to accept a new day, the walls of Overbrook Country Club echoed with the sound of Viva Le Reunion, Allons the 22nd.

Norman J. Quinn, Jr.

1961

Dr. Michael J. Cavoto, 710 Philadelphia Ave., Barnsboro, Pa., established an orthopedic surgery practice in Indiana, Pa., in June. He also was appointed to the Indiana Hospital medical and dental staff. For the past three years he has been assigned as Chief of Orthopedic Surgery with the Air Force 862 Medical Group Hospital at Minot, N. D.

Dr. Roland F. Fleck has joined the staff of the Lansdale Clinic to practice ob-gyn. He was discharged from the Army in May with the rank of Major.

Dr. David W. Knepley, 103 Maple St., Danville, Pa., is pursuing a second residency (in radiology) at Geisinger Medical Hospital. He recently completed three years with the Air Force in Alaska.

Dr. William M. Shue who recently returned from Vietnam, has joined the surgical staff of York Hospital, S. George St. & Rathton Rd., York, Pa. Dr. Shue is a Diplomate of the American Board of Surgery.

Dr. Furman T. Updike, 141 Edgewood Dr., York, Pa., has returned here to practice pediatrics after two years in the Navy. He did his residency at Philadelphia Children's Hospital.

1962

Dr. James F. Bisset, Jr., is now on the staff of the Department of Obstetrics and Gynecology at Easton Hospital, Easton, Pa. He served his internship and residency at Reading Hospital. He had been on active duty with the Air Force since 1966.

Dr. George A. Blewitt, 1515 Trousdale Dr., Burlingame, Calif., is practicing internal medicine in Burlingame with two associates. He has been Board certified. The Blewitts are parents of four children and are "quite happy with life on the San Francisco peninsula."

Dr. Francis B. Boland, N.W. corner of Fairhill & Cheltenham Aves., Philadelphia, is on the medical staff of Doylestown Hospital as of August. He did his residency in orthopedic surgery at Philadelphia General Hospital and Jefferson, and continued post-graduate courses in prosthetics, orthotics, and orthopedic pathology at New York University and Temple University.

Dr. John P. Capelli, 501 Haddon Ave., Haddonfield, N. J., will direct a four bed hemodialysis unit which is being installed at Our Lady of Lourdes Hospital in Camden, N. J. Dr. Capelli is also on the faculty at Jefferson.

Dr. Norman A. Goldstein, 425 W. Cheltenham Ave., Philadelphia, opened offices in July in the Phoenixville Medical Arts Center, where he will practice ENT. He completed a residency in otorhinolaryngology at Temple University Health Sciences Center. He also studied bronchoesophagology at the Jackson Clinic in Philadelphia.

Dr. Stephen Gosin, 4700 Atlantic Ave., Atlantic City, N. J., has joined **Dr. S. Stuart Mally '49**, in his general surgery practice.

Dr. Cyrus L. Mineo has opened an office at 286 Griffith St., Phoenixville, Pa., to practice ophthalmology. He finished his residency at Wills Eye Hospital in Philadelphia recently.

Dr. Jacob A. Orbock, 94 Gibson St., Canandaigua, N. Y., has joined the Canandaigua Medical Group and Thompson Hospital to practice in internal medicine. He recently completed a one year cardiology fellowship at the University of Pennsylvania.

Dr. Joseph W. Sokolowski, Jr., 4313 Greendell Rd., Chesapeake, Va., became Board certified in internal medicine in June and the same month completed his fellowship in pulmonary disease at the U. S. Naval Hospital, St. Albans, N. Y. He has been transferred to the Naval Hospital in Portsmouth, Va., where he is Head of the Pulmonary Disease Branch of the Department of Internal Medicine.

1963

Dr. Francis T. Fitzpatrick, 10 Trebing Lane, Willingboro, N. J., is doing a pediatric practice in Willingboro, and is on the faculty at Jefferson.

Dr. David L. Forde, Laverock Pl., Apt. 19, 1000 Ivy Hill Rd., Philadelphia, recently joined the staff of Chestnut Hill Hospital as Attending Physician in Charge of Pulmonary Diseases. Dr. Forde was Head of the Pulmonary Division, Department of Internal Medicine, at the Naval Hospital in Portsmouth, Va., until his recent discharge from the service.



Dr. Linford K. Gehman '63, is presently serving in Biafra under the American Friends Service Committee and the Mennonite Central Committee. Due to an incorrect press release from a local news service Dr. Gehman was misidentified in the last issue of the Alumni Bulletin.

Dr. Daniel M. Friday, Tyrone, Pa., is responsible for the re-opening of Tyrone Hospital's maternity ward, which has been closed since May 1966. Dr. Friday has opened an ob-gyn practice there, and will practice in a large house trailer on the hospital grounds until construction of facilities is complete. Dr. Friday is the only obstetrics and gynecology specialist on the Tyrone staff.

Dr. Bruce K. Leinweber, 925 Huntingdon Pike, Huntingdon Valley, Pa., is practicing ob-gyn in Philadelphia.

Dr. Joseph A. Slezak, 300 South Hickory St., Scottsdale, Pa., has been appointed to the associate medical staff at Frick Community Hospital in Mt. Pleasant, Pa., with privileges in obstetrics and gynecology.

Dr. Ted Verbinski, 1414 Old Mill Rd., Wyomissing, Pa., announces the association of **Dr. John E. Hillig '62**, in his ob-gyn practice.

1964

Dr. David M. Capuzzi, 1639 Gleneagle Rd., Baltimore, Md., was appointed Osler Resident in Internal Medicine at Johns Hopkins, effective July 1.

Dr. Leroy S. Clark, 5301 Balboa Blvd., Apt. F-5, Encino, Calif., is now Attending Radiologist at Sherman Oaks Hospital in Sherman Oaks, Calif.

Dr. Nils G. Herdelin, Jr., 703 Redman Ave., Haddonfield, N. J., has become associated with **Dr. Thomas H. McGlade, '32**, in the practice of otolaryngology in Camden, N. J.

Dr. Gilles A. Marchand, 25 Keeney Lane, New London, Conn., completed a three year obstetrics and gynecology residency at Lawrence Memorial Hospital in New London, and in July entered practice with two associates.

Dr. John H. Maylock, Peachtree Apt. III, 1424 Sycamore Dr., Apt. H-3, Augusta, Ga., completed two years of pathology residency at Wilkes-Barre General Hospital, Wilkes-Barre, Pa., and is now taking the final two years at the Medical College of Georgia.

Dr. Robert M. Steiner just completed a post-doctoral fellowship in cardiovascular radiology at Stanford University Medical School. He is now in the Air Force, stationed at Homestead AFB (2106-A North Carolina Ave.) Homestead, Fla.

Dr. Norman M. Woldorf, Carriage Hill Apts., #201, 7002 Marcliff, Richmond, Va., is completing an ENT residency at the Medical College of Virginia. The Woldorfs had their first child a year ago.

Dr. John W. Yunginger, 3702 3rd St., N.W., Rochester, Minn., is a pediatric allergy resident at the Mayo Graduate School of Medicine.

1965

Dr. Guido D. Boriosi, 711 Sibley Ave., Old Forge, Pa., opened an office in Scranton, Pa., recently. Dr. Boriosi completed his residency in psychiatry at Warren State Hospital.

Dr. Michael A. Kutell, 6034 Bellaire Blvd., Apt. #422, Houston, Tex., is out of the Air Force and taking a hematology fellowship at Baylor Medical College.

Dr. Edward J. Quinn has joined two associates in their practice of internal medicine. Their offices are located at 36 Old King's Highway South, Darien, Conn. He recently completed a fellowship in rheumatology at Albert Einstein Medical Center in Philadelphia.

Dr. Antonio Ramos-Umpierre, 145 Ave. Hostos, Apt. G-507, Rio Piedras, P. R., finished two years in the Air Force in September. He spent a year in ob-gyn, a year in ophthalmology-ENT, and two years as head of physical exam sections. Now he is a first year resident in ophthalmology at the University of Puerto Rico Medical School Hospitals.

1966

Dr. David S. Colville is a resident in internal medicine at the Mayo Graduate School of Medicine, University of Minnesota at Rochester.

Dr. David W. Jenkins has joined Dr. Charles W. Burroughs in his practice at 34 Scotch Rd., Trenton, N. J. Dr. Jenkins just completed two years with the Air Force at McClellan Air Force Base in Sacramento, Calif.

Dr. Carl L. Reams has been discharged from the Air Force where he spent the last two years as a flight surgeon. "One of my most interesting experiences was my meeting, quite unexpectedly, with Skip Davis (also Jeff '66) on a small island in the Aleutian Island chain, where I had been stationed as the only M.D. I asked for assistance in evacuating a severely injured patient from the island. The search and rescue team diverted the nearest available plane, which just happened to have a Navy flight surgeon on board." Dr. Reams began an otolaryngology residency at Geisinger Medical Center, Danville, Pa., in July.

Dr. Carl R. Steindel, 502 Shiloh Ct., Laurel, Md., is on active duty in the Army, as Captain in the Medical Corp. He is in the orthopedic surgery service at Ft. George Meade, Kimbrough Army Hospital.

Dr. Theodore Wolff finished his pediatric residency at the University of Maryland Hospital in June and is now stationed at Little Rock Air Force Base, Jacksonville, Ark.

1967

Dr. Anthony A. Chiurco, completed his internship at the Pennsylvania Hospital in

Philadelphia and is now with the U. S. Public Health Service in Winnebago, Nebr. He will spend two years at Indian Referral Hospital, serving a five state area. The hospital is affiliated with the University of Nebraska and Creighton University Medical Centers. "Fascinating medical experience."

Dr. Stanley L. Grabias, Jr., Hanover Garden Apt. Q-3, Pottstown, Pa., completed the first year of a general surgery residency at Duke Hospital and in July entered the Army. Long range goal is a return to Duke for orthopedic surgery.

Dr. Johathan Warren, MILPHAP N-2 Adv. Tm #15, Drawer #18 H.A., APO, San Francisco, is spending his second year in the Navy as a medical officer in Vietnam. "The program is called MILPHAP and is sponsored by the U. S. State Department. Three medical officers, one Med Service Corp officer and twelve corpmen work in a Vietnamese hospital. It is very interesting and rewarding. At present I run a peds service."

1968

Dr. William M. Eboch, Jr., is doing a residency in obstetrics and gynecology at Harrisburg General Hospital, Harrisburg, Pa.

Dr. Martina M. Mockaitis, Radcliff House, B-239, Rosemont, Pa., has been named Assistant Acting Chief Resident in Medicine at Bryn Mawr Hospital, Bryn Mawr, Pa.



The Waialae Country Club in Hawaii was site for Jefferson Alumni dinner meeting on September 30. President Peter A. Herbut was guest speaker. Dinner chairman, Dr. Robert Lee forwarded the above photo.

LEFT TO RIGHT: FIRST ROW—Robert Lee '54, Ray Bruist '56, Albert Ho '42, Tom Min '42, James Wong '44, Gail Li '47, Joseph Lerner '34, Henry Yim '56, Walt Young '60, Francis Kaneshiro '40; **SECOND ROW**—Mrs. Al Kong, Mrs. Robert Lee, Mrs. Ray Bruist, Mrs. Albert Ho, Mrs. James Wong, Dr. Herbut, Mrs. Herbut, Mrs. Robert Wong, Robert Wong '36, Mrs. Francis Kaneshiro, Mrs. Tom Min; **THIRD ROW**—Mrs. Walt Young, Mrs. John Carson, John Carson '56, L. T. Chun '44, Mrs. Chun, Gordon Liu '48, Ed Ames—former bacteriologist at Jeff, Mrs. Ames, Mrs. Fred Dodge, Miss Anna Lee, Nat Ching '59, Mrs. S. K. Wong, S. K. Wong '45, Mrs. H. C. Chang, H. C. Chang '37, Phil Chu—former pathology instructor, Mrs. Chu, Mrs. Gail Li, Mrs. Bernard Fong, Mrs. Henry Yim, Bernard Fong '52, Al Kong '59, Francis Au '49; **FOURTH ROW**—Fred Dodge '61, Mrs. Carl Boyer, Carl Boyer '55, Mrs. Hiatt, Mrs. Cimochowski, George Cimochowski '67, Jerry Hiatt '68.

Obituary

Hospital, Cleveland, Ohio, where he was a member of the staff. Dr. Evens had been a general practitioner for fifty-four years, and was active until the time of his death.

Clyde J. Bibb, 1913

Died May 10, 1969 in Reno, Nevada.

James M. Torrence, Jr., 1913

Died July 15, 1969 in Erie, Pa., after a long illness. He had practiced in St. Marys, Pa., for the last thirty years.

Charles T. Vernon, 1913

Died August 18, 1969 in New Jersey. He was a medical examiner for the Travelers Insurance Company for more than thirty years. He is survived by his wife, Clara, and two daughters.

Morris Segal, 1917

Died August 24, 1969 in Philadelphia. Dr. Segal was Chief Surgeon at Albert Einstein Medical Center, Northern Division, in Philadelphia for ten years, retiring when he was 65. He also was Attending Surgeon at St. Luke's and Children's Medical Center and at Germantown Hospital.

Harold C. Kelley, 1918

Died July 3, 1969 in New York. He had been a past President of the American Society of Anesthesiologists and served as President of the Medical Board of Union Hospital in the Bronx.

James Balph, Jr., 1920

Died August 22, 1969 in Philadelphia. He had practiced in South Hills, Pa., for forty-eight years. He was staff member at Magee-Womens and Presbyterian-University of Pennsylvania Hospitals. He is survived by his wife, Helen, a daughter and a son.

Henry D. Solomon, 1922

Died May 19, 1969 in St. Petersburg, Fla. He was on the staffs of the Mercy, St. Anthony, American Legion, Mound Park and Crippled Children's Hospitals in Florida.

Clarence W. Bailey, 1925

Died January 30, 1969 in Duke University Hospital in Durham, N. C.

Howard H. Bradshaw, 1927

Died August 11, 1969 in Winston-Salem, N. C. He had served as Professor of Surgery and Director of the Department of Surgery at Bowman Gray Medical School. Prior to returning to North Carolina in 1941. Dr. Bradshaw was Instructor of Surgery at Jefferson. He also was a Chairman of the Board of Governors of the American College of Surgeons. He had been actively involved with the work of the Board since 1957. His wife, Jeanne, a son and two daughters survive him.

Lester L. Bartlett, 1929

Died June 17, 1969 in Pittsburgh. He had practiced allergy in the Pittsburgh area for the last forty years. For twenty-five years he had been a staff physician at the Pittsburgh Health Department. His wife, Verna, two daughters and a son survive him.

Edward C. Guyer, 1930

Died February 20, 1969 in Seattle, Washington.

Russell M. Hartman, 1930

Died July 28, 1969. He had a practice in Fleetwood, Pa.

Alonzo W. Hart, 1934

Died September 27, 1968. Dr. Hart resided in Philadelphia.

Raymond W. Biggar, 1940

Died July 5, 1969 in Philadelphia. He had been a Red Cross physician.

Joseph S. Rangatore, 1945

Died July 1, 1969 in Downey, Ill. He had practiced in Niagara Falls, N. Y., for ten years before leaving in 1960. He was Chief of Staff at Veterans Hospital in Downey at the time of his death. He is survived by his wife, Margaret, and five daughters.

John R. Sabol, 1957

Died July 27, 1969 after a ten months, illness. Dr. Sabol was an orthopedic surgeon who served on the staffs of Williamsport, Divine Providence, Lewisburg Community, Jersey Shore and Muncy Valley Hospitals. His wife, Louise, also a physician, and two daughters survive him.

Louis D. Donaldson, 1900

Died July 10, 1969 in Gibsonia, Pa. He was attributed with delivering nearly every baby born in the Stahls-town, Pa., area during the 1920's and until his retirement in 1936.

Charles J. Stybr, 1900

Died August 29, 1969. He had a general practice in Pittsburgh, Pa., from 1901 until 1963, and had served as surgeon for the Baltimore and Ohio Railroad for more than fifty years. In 1907 he was the medical examiner for the Austria-Hungary consulate. Dr. Stybr had emigrated in 1882. He is survived by his wife, a daughter and two grandchildren, one of whom is Dr. Ralph Crawford '65.

John F. Evens, 1908

Died May 31, 1969 in Euclid General



Dr. Elmer H. Funk, Jr. '47
510 Millbrook Rd.
Devon, Pa. Chester Co. 19333

